STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285287	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MITCHELL CARE CENTER	1723 23RD STREET MITCHELL, NE 69357

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.04C3a (6) Based on record reviews and interview, the facility failed to notify the physician of one sampled resident's (Resident 2) blood sugar (a blood test to determine the glucose level in the blood) readings above 400 mg/dL (milligrams of glucose per deciliter of blood) as directed in the resident's sliding scale [MED] orders. Sample size was 15 current residents. Facility census was 42. Findings are: Record review of a physician's orders [REDACTED]. Among the ordered parameters, the physician ordered 14 units of [MEDICATION NAME] for blood sugar readings from 401-450 mg/dL with instructions to call MD (Medical Doctor) for readings above 400. Record review of Resident 2's Medication Administration Record [REDACTED]. Further review of the record revealed an order for [REDACTED]. Further review of the record revealed on [DATE] at 11:00 a.m. the resident's blood sugar reading was 452. At 5:00 p.m. on [DATE] the resident's blood sugar reading was 465. Record review of Resident 2's medical record revealed there was no evidence the MD was notified on [DATE] at 11:00 a.m. or on [DATE] at 5:00 p.m. for blood sugar readings above 401. Interview on 3/12/2020 at 7:55 a.m. with the facility's Director of Nursing confirmed Resident 2's blood sugar reading tests on 3/2/20 at 11 a.m. and 3/2/20 at 5 p.m. exceeded 400 mg/dL. The Director of Nursing confirmed the physician orders [REDACTED]. was notified of the elevated blood sugar readings per the order.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** Licensure Reference Number: 175 NAC 12- (21) Based on observations, record review and interview; the facility failed to ensure privacy was provided during personal cares to prevent unnecessary exposure of the body for one current sampled resident (Resident 35). The facility census was 42 with 15 sampled residents. Findings are: Observations of Resident 35 on 3/10/20 at 8:40 AM revealed NA (Nursing Assistant) - A transferred the resident from the wheelchair to the bed for urinary catheter care. Further observations revealed that NA - A lowered the resident's slacks to the resident's knees, opened the disposable brief and provided skin care and catheter care with no draping or cover to promote privacy and comfort and to prevent unnecessary exposure of the body. Interview with the Director of Nursing on 3/10/20 at 3:05 PM confirmed that the staff were to cover or drape residents during personal cares to to promote privacy and comfort.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Licensure Reference Number: 175 NAC 12-006.18A (1) Based on observations and interview, the facility failed to ensure cracked and discolored floor tiles in the room occupied by one sampled resident (Resident 18) and one non-sampled resident (Resident 22) were replaced. Sample size included 15 current residents. Facility census was 42. Findings are: - Observation on [DATE]20 at 11:50 a.m. revealed four square floor tiles in the room occupied by Residents 18 and 22 were cracked with black discolorations on the surfaces of the tile. - Observation on 3/11/2020 at 7:45 a.m. revealed four square floor tiles in the room occupied by Residents 18 and 22 were cracked with black discolorations on the surfaces of the tile. Interview with the Administrator on 3/11/2020 on 7:50 a.m. following the observation of Residents 18 and 22 room verified the floor tiles in the room that were cracked and discolored needed replacement.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(9) Based on observation, interviews, and record review, the facility failed to ensure that three non-sampled residents (Residents 4, 9, and 40) were free from verbal abuse by one staff member. The facility census was 42. Sample size was 15. Findings are: During the Resident Council interview on [DATE]20 at 3:05 PM, Resident 40 voiced concerns that staff are not always polite and that some NAs (Nurse Aids) may be a bit rough. Resident 40 also expressed that these concerns had been raised in Resident Council meetings previously but without much change. Residents 2, 7, 13, 26, and 36 were also present for the interview and voiced agreement with Resident 40's concerns. Review of the Resident Council Agenda for the past three months did not include this concern. However, regarding Administration, every month the note read ok. Would like to see them out of the office more. No response to this was found in the follow up notes. A Grievance Form from Resident 3 dated 1/7/2020 indicated concern about staff being loud and inappropriate with comments for which the facility planned to educated staff. A follow-up with the resident on 1/20/2020 indicated it was getting better with being quiet but did not address inappropriate comments. On 3/11/2020 at 10:41 AM, the facility's Abuse Prevention Policy was reviewed with the Administrator and found to contain all necessary elements based on the Abuse Prohibition Review. Under definitions, the following was noted Verbal Abuse - Use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance. The policy also stated 1. An employee of Mitchell Care Center shall not knowingly: b. Fail to report an incident or suspected incident of abuse, and 7. Records of all allegations will be filed in the accused employee's personnel record along with any statement by the employee disputing the allegation .Records concerning unfounded allegations will be destroyed. Review of NA-D's personnel record showed no reports of any allegations. On 3/11/2020 at 11:30 AM, NA-D was heard speaking rudely to Resident 4 in room [ROOM NUMBER] asking if the resident wanted to go to lunch and saying I'm not playing with you, do you want to go to lunch or don't you in a voice loud enough to be heard down the hall in the conference room. NA-D was observed to continue speaking rudely to Resident 4 while pushing the resident's wheelchair down the hall to the dining room. The Administrator was asked to come observe the situation and saw NA-D at the nurses' desk shouting at Resident 9 who was on the other side of the desk outside the dining room. On 3/11/2020 at 1:15 PM, the Administrator revealed that NA-D had been sent home immediately following that incident. On 3/11/20 at 4:26 PM, an interview with NA-E revealed they had seen but could not clearly hear the entire interaction between NA-D and Resident 9. NA-E stated they believed the two were arguing and immediately attempted to report what was happening to the Administrator. NA-E found the Administrator nearby and already able to see the situation, so they did not say anything at that time. NA-E revealed having had concerns about how NA-D treated residents in the past which had been reported to LPN (Licensed Practical Nurse)-C and also to the Social Service coordinator. NA-E acknowledged they had not shared the concerns with the Administrator as they

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

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) believed the other staff members they spoke to would do that. On 3/11/20 at 4:32 PM, an interview with Resident 9 who was alert and oriented revealed that this resident felt NA-D often spoke with a very loud voice and sounded angry when speaking to residents. Resident 9 verified that they had observed NA-D speaking loudly and rudely to another resident at lunch time and had asked what they had done because NA-D seemed angry with Resident 4 while taking them into the dining room. Resident 9 reported that NA-D had said to mind your own business and stop butting in to my conversations. Resident 9 also revealed that there had been a previous incident when NA-D was heard speaking loudly to another resident in the dining room. Resident 9 reported they had tried to discuss that using a loud voice made NA-D seem angry but was told it was none of their business which caused them to feel embarrassed because their tablemate heard the exchange. Resident 9 was not sure if any other staff heard that incident. The resident also said they did not report the incident due to embarrassment and because they felt they should have waited to speak to NA-D in private rather than starting the conversation in the dining room in front of others. On 3/12/2020 at 7:51 AM, an interview with the Administrator revealed that concerns related to NA-D had never been brought to their attention, and the Administrator had not seen this issue in the past. On 3/12/2020 at 8:15 AM, an interview with a staff member who requested to remain anonymous verified that this individual saw the incident at the nurses desk yesterday, and they described seeing NA-D tell Resident 9 to mind their own business and stay out of their conversations. The anonymous staff member was unable to leave what they were doing at the time and asked NA-E who was also at desk to go tell someone what was happening. The anonymous staff member reported seeing NA-E walk toward the Social Service office and believed that the Social Service coordinator had been notified of the incident. On 3/12/2020 at 8:25 AM, during a phone interview LPN-C stated a long time ago and couldn't recall when, NA-E reported that NA-D was being rude to Resident 25 resulting in the resident crying while a family member was visiting. NA-E couldn't say specifically what was said just that tone used by NA-D was rude. LPN-C immediately went to Resident 25 and their family member to ask about this and was told they had no concerns at that time. LPN-C then spoke with NA-D regarding the concern from another NA about their tone of voice with residents and counseled NA-D to try to keep their tone calm and polite. LPN-C reported they then told the DON (Director of Nursing) about the incident. On 3/12/2020 at 8:30 AM, an interview with the DON revealed they did not recall LPN-C reporting the incident and indicated that no written report of that incident was made. On 3/12/2020 at 8:36 AM, an interview with another staff member who asked to remain anonymous revealed that this staff member had heard NA-D tell several resident including Resident 4, Resident 9, and Resident 40 to mind their own business and to move away from nurse's desk. The anonymous staff member felt this had happened when staff were discussing other residents and felt that NA-D might have had HIPPA concerns. However, the anonymous staff member was certain that NA-D's tone was rude, and NA-D had been told to calm down and not to talk to residents like that. The anonymous staff member believed a Charge Nurse had been present at times when those kinds of conversations happened but could not be sure which licensed nurse was there. The staff member was sure these concerns had been reported to the Social Service coordinator but did not know if the Administrator was notified. The anonymous staff member reported that the Social Service coordinator had told concerned staff members that it was just NA-D's personality to speak loudly. On 3/12/2020 at 8:51 AM, a second interview with the first staff member who asked to remain anonymous revealed that they saw the incident at lunch time the previous day involving NA-D standing at the desk shouting at Resident 9. This staff member also revealed an incident which took place in the morning before the lunch time event. The staff member reported that Resident 40 had complained that NA-D and another NA working at night had said the resident was too fat for their wheelchair which was why it kept breaking. The staff member said that Resident 40 repeated this concern to multiple people all morning. After NA-D came to work, Resident 40 repeated the concern again within NA-D's hearing, and while Resident 40 was in their wheelchair outside the dining room, NA-D told Resident 40 it was true that they were too fat for their wheelchair and needed to scoot their butt back in the wheelchair in the presence of other staff and residents. This anonymous staff member stated they reported this incident to the Social Service coordinator and that the LPN-F had been present for that conversation. This anonymous staff member reported NA-D was often rude to Resident 4, Resident 16, and Resident 25. This staff member reported hearing NA-D tell Resident 25 to stop grabbing things and do what I tell you. The anonymous staff member stated NA-D's tone was worse than the actual words. This staff member revealed that a group of those NAs and MAs on duty had discussed these concerns with the Charge Nurse on duty in the past because it seemed like it happened almost daily. This staff member reported that the response was that it was just NA-D's personality. This staff member revealed that they had told LPN-C and an RN (Registered Nurse) who no longer works at the facility about these concerns. This staff member acknowledged that they had not reported their concerns directly to the Administrator. This anonymous staff member also reported that NA-E had told them that the Social Service coordinator had been told of these concerns. On 3/12/20 at 9:08 AM, a third staff member who asked to remain anonymous reported they did not usually work with NA-D because that staff member normally worked evening shift. However, this staff member verified that they had heard other staff members complain that NA-D was gruff or snotty with residents. This staff member asked the others if they had told anyone and got no answers, so this staff member told the Charge Nurse on duty at that time about what had been heard from other staff members. This staff member did not speak to the Administrator about the concerns. On 3/12/2020 at 9:26 AM, an interview with the Social Service coordinator, the DON, and the Administrator regarding these concerns raised by multiple staff members revealed that all staff had been educated to notify the Administrator personally of concerns at any time and that no one had done so. The DON also reported that no one had shared concerns with them. The Social Service coordinator verified that NA-E told her about NA-D telling Resident 40 they were fat but didn't have time to do anything about it before the other situation occurred and NA-D was sent home. The Administrator revealed that NA-D had been suspended and would likely be terminated pending the completion of their investigation. On 3/12/2020 at 10:00 AM, an interview with Resident 40 verified that NA-D did call them fat which they found offensive. Resident 40 verified they had told other staff members about this concern and they were satisfied with the results as NA-D left the facility and did not come back to work today. On 3/12/2020 at 10:24 AM, these concerns were reviewed with the Administrator and DON who both verified that they had not received reports related to other staff members' concerns about NA-D's treatment of [REDACTED].
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(7) Based on observation, interviews, and record review, the facility failed to ensure that staff members identified and reported incidents related to possible verbal abuse and failing to treat residents with dignity for three non-sampled residents (Residents 4, 9, and 40). The facility census was 42. Sample size was 15. Findings are: During the Resident Council interview on [DATE]20 at 3:05 PM, Resident 40 voiced concerns that staff are not always polite and that some NAs (Nurse Aids) may be a bit rough. Resident 40 also expressed that these concerns had been raised in Resident Council meetings previously but without much change. Residents 2, 7, 13, 26, and 36 were also present for the interview and voiced agreement with Resident 40's concerns. Review of the Resident Council Agenda for the past three months did not include this concern. However, regarding Administration, every month the note read ok. Would like to see them out of the office more. No response to this was found in the follow up notes. A Grievance Form from Resident 3 dated 1/7/2020 indicated concern about staff being loud and inappropriate with comments for which the facility planned to educated staff. A follow-up with the resident on 1/20/2020 indicated it was getting better with being quiet but did not address inappropriate comments. On 3/11/2020 at 10:41 AM, the facility's Abuse Prevention Policy was reviewed with the Administrator and found to contain all necessary elements based on the Abuse Prohibition Review. Under definitions, the following was noted Verbal Abuse - Use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance. The policy also stated 1. An employee of Mitchell Care Center shall not knowingly: b. Fail to report an incident or suspected incident of abuse, and 7. Records of all allegations will be filed in the accused employee's personnel record along with any statement by the employee disputing the allegation .Records concerning unfounded allegations will be destroyed. Review of NA-D's personnel record showed no reports of any allegations. On 3/11/2020 at 11:30 AM, NA-D was heard speaking rudely to Resident 4 in room [ROOM NUMBER] asking if the resident wanted to go to lunch and saying I'm not playing with you, do you want to go to lunch or don't you in a voice loud enough to be heard down the hall in the conference room. NA-D was observed to continue speaking rudely to Resident 4 while pushing the resident's wheelchair down the hall to the dining room. The Administrator was asked to come observe the situation and saw NA-D at the nurses' desk shouting at Resident 9 who was on the other side of the desk outside

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On 3/11/20 at 4:32 PM, an interview with Resident 9 who was alert and oriented revealed that this resident felt NA-D often spoke with a very loud voice and sounded angry when speaking to residents. Resident 9 verified that they had observed NA-D speaking loudly and rudely to another resident at lunch time and had asked what they had done because NA-D seemed angry with Resident 4 while taking them into the dining room. Resident 9 reported that NA-D had said to mind your own business and stop butting in to my conversations. Resident 9 also revealed that there had been a previous incident when NA-D was heard speaking loudly to another resident in the dining room. Resident 9 reported they had tried to discuss that using a loud voice made NA-D seem angry but was told it was none of their business which caused them to feel embarrassed because their tablemate heard the exchange. Resident 9 was not sure if any other staff heard that incident. 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The staff member was sure these concerns had been reported to the Social Service coordinator but did not know if the Administrator was notified. The anonymous staff member reported that the Social Service coordinator had told concerned staff members that it was just NA-D's personality to speak loudly. On 3/12/2020 at 8:51 AM, a second interview with the first staff member who asked to remain anonymous revealed that they saw the incident at lunch time the previous day involving NA-D standing at the desk shouting at Resident 9. This staff member also revealed an incident which took place in the morning before the lunch time event. The staff member reported that Resident 40 had complained that NA-D and another NA working at night had said the resident was too fat for their wheelchair which was why it kept breaking. The staff member said that Resident 40 repeated this concern to multiple people all morning. After NA-D came to work, Resident 40 repeated the concern again within NA-D's hearing, and while Resident 40 was in their wheelchair outside the dining room, NA-D told Resident 40 it was true that they were too fat for their wheelchair and needed to scoot their butt back in the wheelchair in the presence of other staff and residents. This anonymous staff member stated they reported this incident to the Social Service coordinator and that the LPN-F had been present for that conversation. This anonymous staff member reported NA-D was often rude to Resident 4, Resident 16, and Resident 25. This staff member reported hearing NA-D tell Resident 25 to stop grabbing things and do what I tell you. The anonymous staff member stated NA-D's tone was worse than the actual words. This staff member revealed that a group of those NAs and MAs on duty had discussed these concerns with the Charge Nurse on duty in the past because it seemed like it happened almost daily. 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This staff member did not speak to the Administrator about the concerns. On 3/12/2020 at 9:26 AM, an interview with the Social Service coordinator, the DON, and the Administrator regarding these concerns raised by multiple staff members revealed that all staff had been educated to notify the Administrator personally of concerns at any time and that no one had done so. The DON also reported that no one had shared concerns with them. The Social Service coordinator verified that NA-E told her about NA-D telling Resident 40 they were fat but didn't have time to do anything about it before the other situation occurred and NA-D was sent home. The Administrator revealed that NA-D had been suspended and would likely be terminated pending the completion of their investigation. On 3/12/2020 at 10:00 AM, an interview with Resident 40 verified that NA-D did call them fat which they found offensive. Resident 40 verified they had told other staff members about this concern and they were satisfied with the results as NA-D left the facility and did not come back to work today. On 3/12/2020 at 10:24 AM, these concerns were reviewed with the Administrator and DON who both verified that they had not received reports related to other staff members' concerns about NA-D's treatment of [REDACTED].
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.** Licensure Reference Number: 175 NAC 12- D1c Based on observations, record reviews and interview; the facility failed to ensure that assistance was provided with meals when needed for one sampled resident (Resident 35) who was dependent on staff for assistance and cueing to eat. The facility census was 42 with 15 sampled residents. Findings are: Observations on [DATE] at 7:45 AM revealed Resident 35 seated in a wheelchair in the dining room with head down, eyes closed. Further observations at 8:15 AM revealed the resident took sips of juice and a couple of bites of food, then played with the food, moving it around the plate and on top of covered glasses. Several staff walked by the resident and did not stop to assist or cue the resident to eat and drink. Observations on 3/10/20 at 6:45 AM revealed the resident seated in the wheelchair in the dining room with head down and eyes closed. At 7:40 AM, dietary staff delivered the resident's breakfast tray and cut up the food. The resident woke up and took a few bites of food and then started playing with the food, moving it off of the plate and onto the table. Further observations revealed no staff assistance was provided until 8:15 AM and the resident accepted a few bites of food and some juice. Review of the care plan, goal date 5/17/20, revealed that the resident was cognitively impaired and required extensive assistance of one staff member with eating. Interview with the Director of Nursing on 3/10/20 at 3:05 PM confirmed that the staff were to assist and cue the resident with meals in a timely manner to ensure that nutrition and hydration needs were met.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.**

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F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.09D Based on observations, record reviews and interview; the facility failed to ensure that assessments were completed and documented related to 1) a urinary tract infection for one current sampled resident (Resident 13) and 2) [MEDICAL CONDITION] (swelling) and redness at the lower extremities for one current sampled resident (Resident 21). The facility census was 42 with 15 sampled residents. Findings are: A. Review of Resident 13's Progress Notes revealed that on [DATE] at 6:41 PM, the resident was seen by a provider and an order was received for a urinalysis with possible culture. Further review revealed that on 3/10/20 at 1:07 PM, an order was received for [MED] (antibiotic) two times a day for seven days as the urinalysis was positive. Further review revealed no documented assessment of the resident's condition, including symptoms of a urinary tract infection. Interview with the Director of Nursing on 3/10/20 at 3:00 PM confirmed that staff were to assess the resident's condition and document any change of condition, including symptoms of a urinary tract infection and follow up as needed to ensure that the resident's needs were met. B. Observations of Resident 21 on [DATE] at 9:07 AM revealed the resident seated in a wheelchair in room. Further observations revealed both lower extremities had redness and swelling from the feet to upper shins. Interview with the resident on [DATE] at 9:07 AM revealed that was having a lot of pain in feet and legs. Observations on 3/10/20 at 4:30 PM revealed that the resident's lower extremities remained swollen and reddened. Review of the Progress Notes revealed no assessment of the residents swelling and redness at the lower extremities. Interview on 3/10/20 at 10:30 AM with LPN (Licensed Practical Nurse) - C, Charge Nurse, revealed that the resident has had problems with pain and swelling at the lower extremities and had some testing done last month which came back negative. Interview with the Director of Nursing on 3/10/20 at 2:45 PM revealed that there was no skin assessment or documentation in the progress notes that addressed the swelling and redness at the resident's lower extremities. Further interview confirmed that assessments should be completed to monitor changes in condition and identify the need for further evaluation or changes in nursing or medical care to ensure that the resident's needs were met.
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 observations, record review and interviews; the facility failed to ensure that a gait belt (transfer belt applied around the resident's waist for staff to hold on to transfer residents in a safe and comfortable manner) was used to transfer two current sampled residents (Residents 6 and 35). The facility census was 42 with 15 sampled residents. Findings are: A. Observations of Resident 6 on [DATE] at 9:10 AM and on 3/10/20 at 8:30 AM revealed NA (Nursing Assistant) - A transferred the resident from the wheelchair to the bed without utilizing a gait belt. Review of the care plan, goal date 6/1/20, revealed that the resident required extensive assistance of one staff with transfers. B. Observations of Resident 35 on [DATE] at 9:05 AM revealed that NA - A transferred the resident from the wheelchair to the recliner without utilizing a gait belt. Further observations on 3/10/20 at 8:40 AM revealed NA - A transferred the resident from the wheelchair to the bed without utilizing a gait belt. Review of the care plan, goal date 5/17/20, revealed that the resident required extensive assistance of one staff with transfers. Interview with NA - A on 3/10/20 at 10:45 AM revealed forgot to use a gait belt for transfers. Interview with the Director of Nursing on 3/10/20 at 3:30 PM confirmed that the staff were to utilize a gait belt for transfers to ensure a safe and comfortable transfer for the residents and staff.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.09D3 Based on record reviews and interview, the facility failed to complete a bowel and bladder assessment for one current sampled resident (Resident 13) with a decline in bowel and bladder continence (ability to control the bowel and bladder). The facility census was 42 with 15 sampled residents. Findings are: Review of Resident 13's MDS (Minimum Data Set, a federally mandated comprehensive assessment tool used for care planning), dated 10/6/19, revealed that the resident was continent of bowel and was occasionally incontinent (less than seven episodes of incontinence). Review of the MDS, dated [DATE], revealed that the resident was frequently incontinent of bowel(two or more episodes of bowel incontinence, but at least one continent bowel movement) and was frequently incontinent (seven or more episodes of urinary incontinence, but at least one episode of continent voiding). Interview with the Director of Nursing on 3/10/20 at 3:00 PM confirmed that a bowel and bladder assessment was not completed after the decline in continence was identified. Further interview confirmed that further assessments were needed to identify causal factors related to the declines and to develop a plan to restore continence or to prevent further declines.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.09D6(1) Based on observations, record review and interviews; the facility failed to ensure that the head of the bed was elevated for safe administration of medications through a gastric (stomach) tube for one sampled resident (Resident 2). The facility census was 42 with 15 sampled residents. Findings are: Observations on 3/10/20 at 7:15 AM revealed LPN (Licensed Practical Nurse) - C, Charge Nurse, prepared routine morning medications, to be administered per gastric tube, for Resident 2. Further observations revealed the resident in bed with the head of the bed elevated approximately 20 degrees. LPN - C administered the medications through the gastric tube without elevating the head of the bed to 45 degrees. Interview with LPN - C on 3/10/20 at 10:20 AM confirmed that the head of the bed was not elevated to at least 45 degrees for the administration of the medications per the gastric tube. Interview with the Director of Nursing on 3/10/20 at 2:00 PM confirmed that the nurses were to follow the facility procedures and elevate the head of the bed at semi fowler's position, which is 45 %, for medication administration per the gastric tube to decrease the risk of gastric reflux or aspiration (breathing in foreign matter into the lungs). Review of the facility Administering Medication through a PEG- Tube: Observation for Competency, not signed or dated, revealed the following including: Purpose: The purpose of this procedure is to administer medications through a PE[DEVICE] (gastric tube). 8. Ascertain adequate privacy and assist the resident into the Semi-Fowler's position (45%), unless otherwise instructed .
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** Licensure Reference Number: 175 NAC 12-006.09D Based on observations, record review and interviews; the facility failed to further assess pain for one current sampled resident (Resident 21) with almost constant severe pain. The facility census was 42 with 15 sampled residents. Findings are: Review of Resident 21's MDS (Minimum Data Set, a federally mandated comprehensive assessment tool used for care planning), dated 1/27/20, revealed that the resident had almost constant pain, rated 7 on a numeric scale 00 -10 with 00 indicating no pain and 10 indicating the worst possible pain. Observation of the resident on [DATE] at 9:03 AM revealed the resident seated in the wheelchair in room with noted facial grimacing and tears in the eyes. Interview with the resident on [DATE] at 9:03 AM revealed that had terrible pain, pointing to the left shoulder and both feet and legs. Interview on 3/10/20 at 10:30 AM with LPN (Licensed Practical Nurse) - C, Charge Nurse, revealed that the resident received routine pain cream and pain medications. Interview with the Director of Nursing on 3/10/20 at 2:45 PM revealed that there were no further pain assessments completed to include the location of the pain, duration, cause or precipitating factors and interventions, including non pharmacological, to manage the resident's ongoing pain. The DON confirmed that pain, rated 7, indicated significant, severe pain.
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;**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285287	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MITCHELL CARE CENTER	**1723 23RD STREET MITCHELL, NE 69357**

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

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F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) **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 failed to ensure that targeted symptoms of depression were routinely monitored to ensure the effectiveness of a routine antidepressant medication for one current sampled resident (Resident 6). The facility census was 42 with 15 sampled residents. Findings are: Review of Resident 6's MAR (Medication Administration Record), dated March 2020, revealed an order for [REDACTED]. Review of the care plan, goal date 6/1/20, revealed that the resident had a history of [REDACTED]. Interview with the Director of Nursing on 3/10/20 at 3:30 PM confirmed that there was no documentation in the medical record that symptoms of depression were routinely monitored to ensure the effectiveness of the routine antidepressant medication.
F 0923 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have enough outside ventilation via a window or mechanical ventilation, or both.** Licensure Reference Number: 175 NAC 12-007.04D Based on observations and interview, the facility failed to ensure the bathroom mechanical ventilation systems were drawing air into the ductwork to ventilate bathrooms occupied by 2 sampled residents (Residents 39 and 18) and 1 non-sampled resident (Resident 22). Sample size was 15 current residents. Facility census was 42. Findings are: Observations of resident bathroom ventilation systems revealed the following: - [DATE]20 at 8:50 a.m. in the bathroom in the room utilized by Resident 39, the bathroom ventilation system was not drawing any air into the ductwork when tested with a one ply tissue. - 3/11/2020 at 7:45 a.m. with the Administrator revealed Resident 39's bathroom ventilation system was not drawing any air into the ductwork when tested with a one ply tissue. - [DATE]20 at 11:50 a.m. in the bathroom in the room utilized by Residents 18 and 22, the bathroom ventilation system was not drawing any air into the ductwork when tested with a one-ply tissue. The bathroom was observed with a strong urine odor and stale air odor. 3/11/2020 at 7:45 a.m. with the Administrator revealed Residents 18 and 22's bathroom ventilation system was not drawing any air into the ductwork when tested with a one ply tissue. The Administrator acknowledged the bathroom air had a pungent stale odor. Interview with the Administrator on 3/11/2020 at 7:50 a.m. following observations of Residents 39. 18, and 22's bathrooms verified the bathroom ventilation systems were not drawing air into the ductwork in these bathrooms.