STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285266	A. BUILDING _____ B. WING _____	**09/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GATEWAY SENIOR LIVING	**225 NORTH 56TH STREET LINCOLN, NE 68504**

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.** Licensure Reference Number 175 NAC 12-006.10A1 Based on observations, record review and interview, the facility failed to ensure a resident was assesed and competent to safely self-administer medications and to keep medications at the resident's bedside for Resident 7. This affected 1 of 1 sampled residents. The facility census was 64. Findings are: An observation on 9/20/20 at 12:11 PM revealed Resident 7 had a bottle of Refresh eye drops on the bedside table. An interview with Resident 7 on 9/20/20 at 12:11 PM revealed the resident had been self-administering the Refresh eye drops. Review of the facility policy on Administering Medications dated 10/2011 revealed residents may self-administer their own medications once the physician and the Interdisciplinary Care Planning Team have determined the resident has the decision-making capacity to do so safely. Review of Resident 7's current physician orders dated September 2020 revealed there was no documented order for the resident to self-administer the Refresh eye drops. Review of Resident 7's current undated Care Plan did not address the resident was determined safe to self-administer medications. An interview with Clinical Coordinator (CC)-A on 9/23/20 at 8:10 AM confirmed Resident 7 did not have an assessment completed for self-administration of medications and no physician's order had been obtained for the resident to keep the Refresh eye drops at the bedside.
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 ensure the PASRR (Preadmission Screening and Resident Review - a federal requirement to help ensure individuals were not inappropriately placed in nursing homes for long term care) was reevaluated after a new [DIAGNOSES REDACTED]. The facility census was 64. Findings are: A. Review of Resident 21's PASRR dated 4/27/17 revealed under Section I: Mental Illness, Question 1: Does the individual have any of the following Serious Mental Illnesses, the checkbox next to No was checked. The checkbox next to the Psychotic/Delusional Disorder was not marked. Review of Section X: Determination and Outcome revealed the resident did not meet criteria for further review at that time. Review of Resident 21's PASRR Determination letter dated 4/27/17 revealed no further screening was required unless the resident was later suspected or found to have a mental illness. Review of Resident 21's EHR (Electronic Health Record) Medical [DIAGNOSES REDACTED]. Review of Resident 21's MDS (Minimum Data Set - a federally mandated process for clinical assessment of all residents) dated 1/28/20 revealed the [DIAGNOSES REDACTED]. Review of Resident 21's MDS dated [DATE] revealed the [DIAGNOSES REDACTED]. Section A - Identification Information - revealed the resident was not currently considered by the state level II PASRR process to have serious mental illness. Interview on 9/23/20 at 7:39 AM with the Director of Case Management confirmed Resident 21's PASRR was not updated after Resident 21's new [DIAGNOSES REDACTED]. The Director of Case Management confirmed the PASRR should have been updated with the new diagnosis. B. Review of Resident 31's PASARR evaluation dated 2/1/19 revealed no serious mental illness with [DIAGNOSES REDACTED]. Review of Resident 31's MDS dated [DATE] revealed the resident had the following diagnoses; Anxiety Disorder and Depression. There was no [MEDICAL CONDITION] identified. Review of Resident 31's MDS dated [DATE] revealed the resident had the following diagnoses; Anxiety Disorder, Depression, and [MEDICAL CONDITION] (other than [MEDICAL CONDITION]). Review of Resident 31's Order Summary dated 9/23/20 revealed the resident was prescribed [MEDICATION NAME] (a medication classified as an antipsychotic) 25 milligrams (mg) at bedtime for [MEDICAL CONDITION] in the absence of dementia related to Unspecified [MEDICAL CONDITION], Not Due to a Substance or Known Physiological Condition. Review of Resident 31's medical record on 9/23/20 revealed the resident had a [DIAGNOSES REDACTED]. An interview with Clinical Coordinator (CC)-A on 9/23/20 at 8:15 AM confirmed Resident 31's most recent PASARR evaluation was dated 2/1/19 and the resident had not had a new PASARR since the new [DIAGNOSES REDACTED]. C. A record review of the level I PASRR for Resident 16 revealed it did not contain two antidepressant medications that Resident 16 had been admitted with. 09/22/20 03:12 PM An interview with the facility DON (Director of Nursing) confirmed that the level I PASRR did not contain two antidepressant medications that Resident 16 had been admitted with.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** LICENSURE REFERENCE NUMBER 175NAC 12-006.09C1a The facility failed to complete a baseline Comprehensive Care Plan (CCP- written instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care) within 48 hours that included information necessary to provide care related to the PICC line (a peripherally inserted central catheter that is a form of intravenous access that can be used for a prolonged period of time) for Resident 16 and the PICC line and wound vac (a device that drains seeping liquid from a wound that is used to reduce the incidence of infection and aid in the healing process by forming an airtight cover and pumping the liquid out) interventions for Resident 53. Resident sample size was 16. Facility census was 64. Findings are: A record review of the baseline CCP completed within the first 48 hours revealed it did not contain the PICC line use or care related to the UTI (urinary tract infection) for Resident 16. An interview on 09/22/20 at 03:12 PM with the facility DON (Director of Nursing) confirmed that the baseline CCP for Resident 16 did not contain the PICC line use or care of related to the UTI and should have. A record review of the baseline CCP completed in the first 48 hours did not contain the wound vac care interventions, the PICC line use or the Wound Care Clinic (WCC) visits for Resident 53. An interview on 09/22/20 at 03:12 PM with the facility DON confirmed that the baseline CCP for Resident 53 did not contain the wound vac care interventions, the PICC line or the WCC.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure the physician documented a clinical rationale for the contraindication of a GDR (Gradual Dose Reduction) for [MEDICAL CONDITION] medications (a medication capable of affecting the mind, emotions, and behavior) for 1 resident (Resident 21) of 5 residents reviewed. The facility census was 64.

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
	285266	A. BUILDING _____ B. WING _____	**09/23/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GATEWAY SENIOR LIVING	**225 NORTH 56TH STREET LINCOLN, NE 68504**

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 0756 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Findings are: Review of Resident 21's Order Summary Report dated 9/21/20 revealed Resident 21 was ordered: - [MEDICATION NAME] 20 MG ([MEDICATION NAME] Oxalate - a medication used to treat depression and anxiety) by mouth one time a day for dementia (a group of thinking and social symptoms that interferes with daily functioning) and major [MEDICAL CONDITION] (a mental health disorder characterized by persistently depressed mood or loss of interest in activities) - [MEDICATION NAME] 25 MG (Quetiapine [MEDICATION NAME] - an antipsychotic medication that works by changing the actions of chemicals in the brain) by mouth at bedtime for unspecified [MEDICAL CONDITION], not due to a substance or known physiological condition (a mental disorder characterized by a disconnection from reality). Review of Resident 21's Note to Attending Physician/Prescriber dated 5/11/20 revealed the facility consultant pharmacist identified the resident had been receiving [MEDICATION NAME] and Quetiapine. The pharmacist identified nursing staff would not support a dose reduction due to Resident 21 displaying behaviors disruptive to cares and other residents. The pharmacist identified Resident 21 was a candidate for a trial dosage reduction attempt to find the minimal effective dose. On 6/5/20, Resident 21's healthcare provider noted a dosage reduction was clinically contraindicated, but did not include specific rationale explaining why. The healthcare provider's response was noted by an LPN (Licensed Practical Nurse) on 6/7/20. Interview on 9/23/20 at 7:23 AM with the DON (Director of Nursing) confirmed the healthcare provider's clinical rationale for the contraindication of the GDR should have been documented on the form, but the documentation was not completed.