STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285071	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE ESTATES	**2325 LODGE DRIVE GERING, NE 69341**

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 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Reasonably accommodate the needs and preferences of each resident.** Licensure Reference Number: 175 NAC 12-006.04G Based on observations and interviews, the facility failed to ensure the call light was accessible to alert staff when needed for one current sampled resident (Resident 52). The facility census was 85 with 21 current sampled residents. Findings are: Observations on 8/11/20 at 9:30 AM revealed Resident 52 seated in a recliner in room. Further observation revealed no call light within reach of the resident. The call light was found under the bed linens. Interview on 8/11/20 at 9:30 AM with the resident confirmed was not able to find the call light. Interview on 8/12/20 at 10:00 AM with LPN (Licensed Practical Nurse) - A, Charge Nurse, confirmed that the resident used the call light to access staff when needed. Further interview confirmed that the staff were to ensure that the call light was placed within reach so that the resident could use it to access staff when needed.
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: 175 NAC 12-006.09C1b Based on observations, record reviews, and interviews, the facility failed to develop care plans to active problems related to: 1) one sampled resident's (Resident 8) skin condition; and 2) one sampled resident's (Resident 3) use of a seat belt device in the wheelchair. The sample size included 21 current residents. Facility census was 85 Findings are: A. Observation on 08/11/20 at 3:37 p.m. Resident 8 was sitting down in the recliner watching television. Resident was groomed nicely as hair was combed and resident was wearing a short sleeved shirt and slacks. Resident 3's left and right arms were covered in bruises. Resident interview on 08/11/20 at 3:37 p.m. Resident 8 verified having bruises on both left and right arm. Resident 3 confirmed bruising easily due to diabetes and being on [MEDICAL TREATMENT] three times a week. Resident 3 was not sure how all the bruises were obtained, but had stated having bumped into things. Record review - Diagnosis - I69.351 [MEDICAL CONDITION] AND [MEDICAL CONDITION] FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE SLP Acute Neurologic 5/10/2017 Primary 5/10/2017 cschmunk view I69.320 [MEDICAL CONDITION] FOLLOWING CEREBRAL INFARCTION SLP Acute Neurologic 5/10/2017 [DIAGNOSES REDACTED]. on both left and right arms. Record review of Resident 8's assessments confirmed there were no assessments completed identifying Resident 8's bruising to both arms. Staff interview on 08/13/20 at 9:55 a.m. with NA-(Nursing Assistant) - E confirmed that Resident 8 had bruising to both arms and some of this bruising occurred when Resident 8 was at [MEDICAL TREATMENT], however NA-E was not sure of this and NA-E was not clear on how the nurse on duty documented this. Staff interview on 08/13/20 at 10:00 a.m. with LPN (Licensed Practical Nurse) - B verified that they did not chart on Resident 8's bruised arms as this is chronic due to [MEDICAL TREATMENT]. LPN-B Confirmed there is no care plan to address Resident 8's bruised arms. Staff interviews on 08/13/20 at 10:51 a.m. RN (Registered Nurse) - C and LPN (Licensed Practical Nurse) - D both confirmed that Resident 8 did not have any care planning developed to address Resident 8's bruising to both arms. Staff interview on 08/13/20 at 11:27 a.m. The Director of Nursing verified that Resident 8 did not have any care planning developed to address the bruising that had occurred on Resident 8's left and right arm. B. Resident observation on 08/11/20 at 10:15 a.m. Resident 3 was sitting in electric wheelchair at a table in own room while working on a puzzle. Resident 3 was wearing a seat belt/lap belt while sitting in electric wheelchair. Resident observation on 08/12/20 at 8:00 a.m. Resident 3 was sitting in electric wheelchair at a table in own room eating breakfast and Resident 3 was wearing a seatbelt/lap belt that went around the waist and was in a locked position. Resident interview on 08/12/20 at 8:00 a.m. Resident 3 confirmed being able to unlatch the seatbelt on the wheelchair and demonstrated this. Resident 3 only able to use left hand to undo seatbelt as Resident 3's right hand and arm had no functional ability. Record review of Resident 3's Diagnosis - I69.351 [MEDICAL CONDITION] AND [MEDICAL CONDITION] FOLLOWING CEREBRAL INFARCTION AFFECTING RIGHT DOMINANT SIDE SLP Acute Neurologic 5/10/2017 Primary 5/10/2017 cschmunk view I69.320 [MEDICAL CONDITION] FOLLOWING CEREBRAL INFARCTION SLP Acute Neurologic 5/10/2017 [DIAGNOSES REDACTED]. Staff interview on 08/12/20 at 10:30 a.m. NA (Nursing Assistant) - F and NA (Nursing Assistant) -A both confirmed that Resident 3 uses a seatbelt/lap belt when using the electric wheelchair. Staff interview on 08/12/20 at 10:35 a.m. LPN (Licensed Practical Nurse) -G and LPN (Licensed Practical Nurse) -D were both present and verified Resident 3 did not have any care planning developed to address the seatbelt/lap belt being utilized by Resident 3. Staff interview on 08/12/20 at 10:40 a.m. Director of Nursing confirmed Resident 3 had no care planning developed to address the seatbelt/lapbelt that was being used by Resident and stated this should have been care planned.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12-006.09D6(7) Based on observations, record review and interview; the facility failed to ensure that oxygen was administered as ordered by the practitioner for one current sampled resident (Resident 60). The facility census was 85 with 21 current sampled residents. Findings are: Observations on 8/11/20 at 10:48 AM and 2:00 PM revealed Resident 60 seated in a wheelchair in the lounge area with oxygen on per tank at 2 liters per minute. Observations on 8/12/20 at 8:15 AM revealed the resident seated in a wheelchair in the room with oxygen on per concentrator at 2 liters per minute. Review of the TAR (Treatment Administration Record), dated August 2020, revealed an order for [REDACTED]. Oxygen was administered on the evening shift at 4 liters per minute at 8/1, 8/5, 8/8; 3 liters per minute at 8/2, 8/3, 8/7, 8/9, 8/10 and 8/11 and 2 liters per minute on 8/4 and 8/6. Oxygen was administered on the night shift at 4 liters per minute on 8/8; 3 liters per minute on 8/1, 8/2, 8/7, 8/9, 8/10 and 8/11 and at 2 liters per minute on 8/3, 8/4, 8/5 and at 8/6. Interview on 8/12/20 at 10:00 AM with LPN (Licensed Practical Nurse) - A, Charge Nurse, confirmed that oxygen was not administered as ordered by the practitioner.
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 reviews and interview, the facility failed to ensure that behavior logs were completed to monitor symptoms of depression and anxiety for one current sampled resident (Resident 41) taking routine antidepressant and antianxiety medications. The facility census was 85 with 21 current sampled residents.

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) Findings are: Review of Resident 41's MAR (Medication Administration Record), dated August 2020, revealed that the resident routine received Alprazolan (antianxiety) and [MEDICATION NAME] (antidepressant). Review of the Behavior/Intervention Monthly Flow Record, dated July 2020, revealed that the staff monitored the resident for restlessness and potential adverse symptoms including [MEDICAL CONDITION], dizziness and tiredness. Further review revealed no documentation after 7/16/20. Review of the Behavior/Intervention Monthly Flow Record, dated July 2020, revealed that the staff monitored the resident for withdrawal and potential adverse symptoms including dizziness, drowsiness and weight gain. Further review revealed no documentation after 7/17/20. Interview on 8/12/20 at 10:00 AM with LPN (Licensed Practical Nurse) - A, Charge Nurse, confirmed that there was no documentation that the resident's symptoms of anxiety and depression were monitored and documented to ensure that the resident received the therapeutic benefits of the medications.