STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285114	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FALLS CITY CARE CENTER	2800 TOWLE STREET FALLS CITY, NE 68355

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)
E 0004 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and maintain an Emergency Preparedness Program (EP).** Based on interview and review of the facility's Emergency Preparedness (EP) plan, the facility failed to review and update the EP plan annually. The facility's failure to review and update the Emergency Preparedness Plan annually places residents at risk of staff failing to respond correctly in an emergency. Findings are: The Administrator presented the facility's EP plan, which was undated. A review of the EP plan indicated it lacked evidence that the plan was reviewed and updated for implementation as the facility-wide response plan to emergency situations. Interview with the Administrator on 08/03/20 at 1:30 PM confirmed the facility failed to review and update the EP plan as the instruction to staff of how to respond to emergency situations.
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** Based on observation, interviews, record review and policy and procedure review, the facility failed to ensure a resident had been assessed to self-administer medications. This affected one (Resident 32) of one sampled resident. Resident 32 was allowed to self-administer medications without proper assessment. Findings are: Resident 32 was admitted to the facility on [DATE] for acute kidney failure, pressure ulcer of right heel, pressure ulcer on left leg amputation site, type II diabetes, and chronic [MEDICAL CONDITION]. The admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident had no memory impairment. The resident needed extensive assistance for Activities of Daily Living (ADLs). The resident's care plan, dated 06/08/20, documented Resident 32 required medication to manage medical conditions. The intervention was to have medications administered as ordered. A Self-Administration of Medication Assessment, dated 06/15/20, documented Resident 32 had not requested to self-administer medications. On 08/03/20 at 8:39 AM, a souffle cup with six pills was observed on the resident's bedside table. Resident 32 stated resident's preference was to eat breakfast prior to taking the morning medications, due to the potential of an upset stomach. Resident 32 stated the nurse would often leave the morning medications at bedside if the breakfast trays had not yet been passed. The resident was unable to explain what the medications were in the cup, stating, I only worry about what I'm taking prior to going home. Here, I trust the nurses to bring me the medications I'm prescribed. Resident 32 knew how many medications were received during each medication pass but was not able to state the name of any of the medications or why Resident 32 was prescribed that medication. On 08/03/20 at 10:35 AM, Licensed Practical Nurse (LPN)-D was interviewed. LPN-D stated, I believe we all thought that it was OK for (Resident 32) to self-medicate. LPN-D reviewed the documents in the clinical record and stated Resident 32 should not be self-administering medications. LPN-D stated, Today (referring to the medications on the bedside table) was my fault. On 08/03/20 at 2:16 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON had completed the self-administration of medication assessment. The ADON was concerned Resident 32 was not going to be safe self-administering as demonstrated by the inability to properly take insulin injections. The ADON stated Resident 32 was not interested in self-administering medications and the issue was not pushed. The ADON stated the expectation was for nursing staff to observe Resident 32 taking medications at each medication pass. The facility's policy titled, Self-Administration of Medication Policy, dated 08/18 and revised 03/19, documented in part, #5. Nursing to get an order from the physician for self-administration of medications; #7. Documentation of the ability to self-administer medications will appear on the resident's plan of care.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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** Based on record review and staff interviews, the facility failed to inform the resident or resident representative of their right to establish an Advanced Directive and provide assistance if the resident wished to execute an Advanced Directive. This deficient practice affected 50 of 61 residents who did not have an existing Living Will. Findings are: Review of a document identified by Social Worker-E (SW), as the document provided on admission to residents who desire to have an Advanced Directive, was completed on [DATE] at 10:02 AM. The document was titled, Rights of the Terminally Ill Declaration (Nebraska Living Will Declaration). The only treatment options noted on the document were for the physician to withhold or withdraw life-sustaining treatment if the resident was in a persistent vegetative state or had a condition that would cause death in a relatively short time. Review of resident records indicated a document titled, CPR/DNR (cardiopulmonary resuscitation/do not resuscitate) Directive. The form had options to chose full CPR, No CPR or Limited Treatment. Limited treatments included No CPR, do not intubate, no tube feedings and do not hospitalize. Completed documents for Resident 6 and Resident 37 noted No CPR was checked. Nothing was completed under Limited Treatment. On [DATE] at 3:45 PM, an interview was completed with Nurse-C and Nurse-D. After reviewing the CPR/DNR form, both nurses stated that if a resident had chosen No CPR, they would not ask to fill out the Limited Treatment section, since we wouldn't do any of those things. An interview was completed with Nurse-B on [DATE] at 11:00 AM. Nurse-B was the Assistant Director of Nurses (ADON). Nurse-B stated the CPR/DNR Directive form was the advanced directive form that was used unless there was already a current Living Will or Advanced Directive. Nurse-B said residents (or legal representatives) would choose between the options of CPR or No CPR, then complete the Limited Treatment section separately indicating wishes. On [DATE] at 9:54 AM, an interview was completed with Social Worker-E (SW). SW-E stated that on admission, residents or the legal representative are spoken to about Advanced Directives. If there was interest in information about Advanced Directives, they are given the booklet that includes the Rights of the Terminally Ill Declaration (Nebraska Living Will Declaration) form. If there was no interest in Advanced Directives, then no educational information was given. SW-E said that the CPR/DNR directive was for determining CPR status, not advanced directives. The CPR/DNR form discuss code status. The form would be referenced if there was a cardiopulmonary arrest. Staff would look at Limited Treatments if there was no CPR code status selected. SW-E was asked what if CPR was checked and no IV was selected under Limited Treatments, how would staff know if that was for a cardiopulmonary arrest or just a decline in health. After reviewing, SW-E said the document was confusing, I think we need a better form. SW-E acknowledged that Resident 48 and Resident 6 did not have an Advanced Directive and (gender) had not made any notes about discussing Advanced Directives with the residents or responsible parties. On [DATE] at 4:50 PM, the Administrator verified that 11 current residents had Living Wills. All other residents would only have the CPR/DNR form to document treatment wishes. On [DATE] at 1:45 PM, an interview was completed with Resident 6. Resident 6 said they could not remember being asked about any of the items under Limited Treatment, but felt if any treatments were needed, it would be discussed with them or a family member. Resident 6 did verify the desire to not have CPR efforts.

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
	285114	A. BUILDING _____ B. WING _____	**08/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FALLS CITY CARE CENTER	**2800 TOWLE STREET FALLS CITY, NE 68355**

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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1)
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** Based on interviews, record reviews, and review of policy and procedures, it was determined the facility failed to ensure PRN (as needed) orders for [MEDICAL CONDITION] medications were limited to 14 days and included a practitioner evaluation prior to a new 14-day order for one resident (Resident 30) on a PRN anti-psychotic medication; and failed to ensure [MEDICAL CONDITION] medications did not extend beyond 14 days, without a documented rationale, for one resident (Resident 56) on a PRN anti-anxiety medication. Five sampled residents were reviewed for unnecessary medications. Seven residents had orders for PRN [MEDICAL CONDITION] medications. Findings are: 1. Resident 30 had [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The stop date indicated for the PRN ziprasidone order was indefinite. A Medication Administration Record [REDACTED]. On 08/03/20 at 8:19 AM, the Director of Nurses (DON) stated the PRN ziprasidone order did not have a stop date. After this surveyor informed the facility of the concern, a nurse practitioner note, dated 08/03/20, documented, .Clarification -ziprasidone 20 mg (milligram) PO (by mouth) prn agitation, irritability, hallucinations, delusions. Currently no stop date and is reassessed monthly .our last visit was July 9, 2020 . On 08/03/20 at 1:45 PM, the Administrator (ADM) acknowledged the concerns related to stop dates for PRN [MEDICAL CONDITION] medications. The ADM stated this had been a topic of frequent discussion with primary care providers. The ADM stated indefinite was the default stop date for orders in the system when a stop date had not otherwise been entered. A facility policy titled, Psychopharmacologic Medication Assessment and Review Policy, last revised on 03/19, documented, .PRN orders for [MEDICAL CONDITION] drugs are limited to 14 days, except if the attending clinician believes that it is appropriate for use extended beyond 14 days - rationale must be documented and indicate the duration for the PRN use after the physician does an onsite or hands on assessment of the resident . 2. Resident 56 had [DIAGNOSES REDACTED]. A pharmacy consultation report, dated 04/28/20, documented the resident had a PRN order for [MEDICATION NAME], an anti-anxiety medication. The consult report indicated the order did not have a stop date and CMS (The Centers for Medicare & Medicaid Services) required orders for non-antipsychotic [MEDICAL CONDITION] drugs be limited to 14 days, unless the prescriber documents the diagnosed specific condition being treated, the rationale for the extended time period, and the duration for the PRN order . The pharmacy consult report recommended an order duration of six months, for the indication of anxiety with a rationale of long term issues with anxiety . A physician's response, dated 05/05/20, documented I accept the recommendations above . There was no documentation this order had been implemented. Physician orders, dated 07/03/20, indicated [MEDICATION NAME] was to be given PRN, every six hours, for increased anxiety. The stop date indicated for the order was indefinite. A Medication Administration Record [REDACTED]. On 08/03/20, the Director of Nurses (DON) confirmed the PRN order for [MEDICATION NAME] did not have a stop date. The DON acknowledged the pharmacy consultation report, dated 04/28/20, had recommended a six-month continuation of the order, that the recommendation had been accepted by the physician, but the order had not been implemented. The DON stated the nurse who noted the physician's orders [REDACTED]. On 08/03/20 at 1:45 PM, the Administrator (ADM) acknowledged the concerns related to stop dates for PRN [MEDICAL CONDITION] medications. The ADM stated this had been a topic of frequent discussion with primary care providers. The ADM stated indefinite was the default stop date for orders in the system when a stop date had not otherwise been entered. A facility policy titled, Psychopharmacologic Medication Assessment and Review Policy, last revised on 03/19, documented, .PRN orders for [MEDICAL CONDITION] drugs are limited to 14 days, except if the attending clinician believes that it is appropriate for use extended beyond 14 days - rationale must be documented and indicate the duration for the PRN use after the physician does an onsite or hands on assessment of the resident .
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy review, the facility failed to ensure medications were properly labeled with an open and expiration date and failed to remove expired medications from two of two medication carts observed. Finding are: Review of the policy titled, medications: [REDACTED]. No discontinued, outdated, or deteriorated medications/solutions are available for use in this facility. All such medications/solutions are destroyed. The policy did not address resident's multidose vials or a process for monitoring stock medications. The medication cart, identified as the 200-300 hall cart, was examined on 07/30/20 at 8:45 AM. Antacid pills were observed to have expired 09/19, liquid antacid expired 05/20 and [MEDICATION NAME] capsules had expired 06/20. On 07/30/20 at 8:49 AM, an interview was completed with Nurse-A. Nurse-A said that all nursing staff could monitor drug supplies for expiration dates. Night shift cleans the carts so they normally would do it, but it's not officially assigned to anyone. On 07/30/20 at 9:02 AM, an examination of the medication cart identified as the 500-600 hall cart was completed. An open bottle of insulin for Resident 8 had no opened date. A multidose vial anti-psychotic for Resident 42 was dated as opened on 06/22/20. A stock bottle of vitamin D3 had expired 06/20, and a stock bottle of [MEDICATION NAME][MEDICATION NAME] had expired 03/20. An interview was completed with Medication Aide (MA)-I on 07/30/20 at 9:05 AM. MA-I stated that all vials should be dated when they are opened and that open vials were good for 30 days, then would be discarded. An interview was completed with Nurse-B on 07/30/20 at 9:24 AM. Nurse-B was identified as the Assistant Director of Nurses. Nurse-B said the pharmacist was coming out once a month and looking at the medication carts, but because of COVID-19, that wasn't occurring now. Nurse-B also said that medication nurses should be looking for expiration dates on their carts, and open vials should be discarded after being open 30 days. Nurse-B was not aware of any specific staff member being assigned to monitor for expiration dates or open vials.