STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAVER CITY MANOR	**P O BOX 70, 905 FLOYD STREET BEAVER CITY, NE 68926**

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** LICENSURE REFERENCE NUMBER 175 NAC 12-006-05 (21) Based on observation and interview, the facility failed to treat Resident 17 with dignity and respect by wearing gloves and standing looking down at resident when physically assisting resident with eating and drinking noon meal. This affected 1 resident of 21 residents observed during the meal. The facility census was 21. Findings are: Observation on 9/16/20 at 12:15 PM revealed Resident 17 physically assisted by an unidentified nurse aide with noon meal at the nurses station. The nurse aide donned gloves and stood above resident when providing assistance with feeding Resident 17 food and drink. Interview with the DON (Director of Nursing) on 9/22/20 at 11:25 AM revealed there was no policy at this facility regarding using gloves with feeding. The DON confirmed the expectation would be to be at eye level with resident, and not wearing gloves.
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to notify the Ombudsman (a person appointed by the state who advocates for residents' rights) of a facility initiated discharge of hospitalization for 1 of 1 sampled residents (Resident 7). The facility identified a census of 21 at the time of survey. Findings are: Review of Resident 7's Quarterly MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 6/17/2020 revealed an admission date of [DATE]. Review of Resident 7's MDS tracking records revealed Resident 7 was DRA (discharged Return Anticipated) from the facility to an acute care hospital on [DATE]; re-entry 8/25/2020; DRA 8/26/2020 with re-entry to the facility on [DATE] and DRA 9/11/2020 with re-entry to the facility on [DATE]. Review of Resident 7's Progress Notes revealed Resident 7 was discharged to the hospital from the facility on 8/24/2020 and returned on 8/25/2020; discharged to the hospital from the facility on 8/26/2020 and returned 8/28/2020; and discharged to the hospital from the facility on 9/11/2020 and returned on 9/14/2020. Interview with the SSD (Social Services Director) on 9/17/20 at 3:02 PM revealed the facility did not have a procedure for notifying the Ombudsman of facility initiated discharges so this was not occurring. The SSD confirmed the Ombudsman had not been notified about Resident 7's facility initiated discharges to the hospital.
F 0645 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**PASARR screening for Mental disorders or Intellectual Disabilities** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to complete a PASRR (Pre-Admission Screening and Resident Review) assessment for one sampled resident (10). This affected 1 of 1 sampled residents. The facility census was 21. Findings are: Review of Resident 10's Admission Face Sheet revealed Resident 10 was hospitalized and returned to the facility 4/30/2020. Record review of admission records revealed Resident 10 returned to facility on the medication, [MEDICATION NAME] an antipsychotic medication, and the resident had no known indications or [DIAGNOSES REDACTED]. Review of the resident medical record for 4/30/2020, revealed a current PASRR was not available for the resident. Record review of Social Services Director notes from 5/01/2020 revealed on 4/30/20 Resident 10 was admitted from hospital and the progress notes confirmed Resident 10 returned with [MEDICATION NAME] at HS as resident was had an increase in behaviors and was restless. The SSD notified the hospital a new PASRR needed to be completed. On 9/17/2020 at 11:30 AM An interview with SSD (Social Service Director) revealed a PASRR needed to be completed on Resident 10, when resident returned to the facility, on 4/30/2020 and confirmed the PASRR had not been completed. The SSD revealed they thought the hospital would complete the PASRR for the facility.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C1a Based on interview and record review; the facility failed to submit a written summary of the baseline care plan to the resident or resident PR (Personal Representative) for 5 of 7 sampled residents (Resident 7, 8, 19, 21, and 10). The facility identified a census of 21 at the time of survey. Findings are: A. Review of Resident 7's Quarterly MDS dated [DATE] revealed an admission date of [DATE]. Resident 7 had a BIMS (Brief Interview for Mental Status) score of 15 which indicated Resident 7 was cognitively intact. Review of Resident 7's Baseline Care Plan dated 9/20/2019 revealed no documentation a written summary was provided to Resident 7. The Resident and/or Representative signature line was blank. Review of Resident 7's Progress Notes revealed no documentation a written summary of their baseline care plan was given to them. B. Review of Resident 8's quarterly MDS dated [DATE] revealed an admitted on 1/20/2020. Resident 8 had a BIMS score of 12 which indicated moderate cognitive impairment. Review of Resident 8's Baseline Care Plan dated 1/20/2020 revealed no documentation a written summary was provided to Resident 8. The Resident and/or Representative signature line was blank. Review of Resident 8's Progress Notes revealed no documentation a written summary of their baseline care plan was given to them or their PR. C. Review of Resident 19's quarterly MDS dated [DATE] revealed an admission date of [DATE]. Resident 19 had a BIMS score of 14 which indicated Resident 19 was cognitively intact. Review of Resident 19's Baseline Care Plan dated 10/22/2019 revealed no documentation a written summary was provided to Resident 19. The Resident and/or Representative signature line was blank. Review of Resident 19's Progress Notes revealed no documentation a written summary of their baseline care plan was given to them. D. Review of Resident 21's quarterly MDS dated [DATE] revealed an admission date of [DATE]. Resident 21 had a BIMS score of 9 which indicated moderate cognitive impairment. Review of Resident 21's Baseline Care Plan dated 10/22/2019 revealed no documentation a written summary was provided to Resident 21. The Resident and/or Representative signature line was blank. Review of Resident 21's Progress Notes revealed no documentation a written summary of their baseline care plan was given to them or their PR. Interview with the DON (Director of Nursing) on 09/21/20 at 4:09 PM. The written summary of the baseline care plan was not given to the resident/PR. The DON confirmed if there was no signature on the page then it wasn't done. The DON revealed they have been going over the care plan with the resident/PR at the initial care plan meeting but not before. Review of the facility policy Baseline Care Plan dated 1/10/2018 revealed the following: Policy: The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and

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
	285269	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAVER CITY MANOR	P O BOX 70, 905 FLOYD STREET BEAVER CITY, NE 68926

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 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) person-centered care of the resident that meet professional standards of quality care. Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders [REDACTED]. Physician orders. iii. Dietary orders. iv. Therapy services. v. Social services. vi. PASRR recommendation, if applicable. 3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 4. A written summary of the baseline care plan shall be provided to the resident and representative in a language that the resident/representative can understand. The summary shall include, at a minimum, the following: a. The initial goals of the resident. b. A summary of the resident's medications and dietary instructions. c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. E. Record review of Resident 10's admission record revealed the resident was admitted [DATE]. There was no documentation the family for Resident 10 received or acknowledged the baseline care plan. Record review of Resident 10's SSD (Social Services Director) progress notes revealed the resident had been in the hospital and returned on 4/30/2020 and the baseline care plan had not been completed. The comprehensive care plan had been reviewed on 5/13/20. On 09/22/20 at 12:00 PM an interview with the Director of Nursing confirmed that there was no documentation on the Resident 10's baseline care plan that the family had received or acknowledged written receipt of the baseline care plan.
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 12-006.04C3a(5) Based on interview and record review; the facility failed to document a depressive condition and sleep disorder including target behaviors and interventions for adverse medication side effects on the care plan for Resident 7 and failed to implement interventions for bleeding risk on the care plan for Resident 8. This affected 2 of 13 sampled residents. The facility identified a census of 21 at the time of survey. Findings are: A. Review of Resident 7's Quarterly MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 6/17/2020 revealed an admission date of [DATE]. Resident 7 had a BIMS (Brief Interview for Mental Status) score of 15 which indicated Resident 7 was cognitively intact. Resident 7 had a PHQ-9 (PHQ-9-A validated interview that screens for symptoms of depression. It provides a standardized severity score and a rating for evidence of a [MEDICAL CONDITION]) score of 6 which indicated symptoms of mild depression. Active [DIAGNOSES REDACTED]. Antidepressant medication was received 7 days of the 7 day MDS look back period. Review of Resident 7's Encounter Psychotherapy Follow Up Note dated 4/23/2020 revealed Resident 7 had adjustment disorder with depressed mood; chronic recurrent major [MEDICAL CONDITION] and other specified depressive episodes. Review of Resident 7's Order Summary Report dated 9/17/2020 revealed [DIAGNOSES REDACTED]. Resident 7 had orders for duloxetine (antidepressant medication) HCl Capsule Delayed Release Sprinkle 30 MG Give 1 capsule by mouth in the morning related to major [MEDICAL CONDITION] with an active date of 4/09/2020; duloxetine HCl Capsule Delayed Release Sprinkle 60 MG Give 1 tablet by mouth in the evening related to major [MEDICAL CONDITION], recurrent, unspecified, with an active date of 6/24/2020, and [MEDICATION NAME] (a supplement used to induce sleep) Tablet 5 MG Give 1 tablet by mouth in the evening for [MEDICAL CONDITION] with an active date of 6/24/2020. Review of Resident 7's MAR (Medication Administration Record) for September 2020 revealed documentation the duloxetine and [MEDICATION NAME] was administered to Resident 7. Review of Resident 7's Care Plan dated 10/16/2019 revealed no documentation of the [MEDICAL CONDITION] and sleep disorder, the target behaviors of the disorders, or the potential adverse side effects of the medications the facility staff should be monitoring the resident for. B. Review of Resident 8's quarterly MDS dated [DATE] revealed an admission date of [DATE]. Resident 8 had a BIMS score of 12 which indicated moderately impaired cognition. Resident 8 received anticoagulant medication 7 days of the 7 day MDS look back period. Review of Resident 8's Order Summary Report dated 9/21/2020 revealed an order for [REDACTED]. Review of Resident 8's Care Plan dated 2/4/2020 revealed no documentation of the use of the blood thinner, bleeding risk, or interventions to prevent bleeding related to the use of the blood thinner. Interview with the DON (Director of Nursing) on 9/22/2020 at 9:31 AM revealed the care plans were to be updated in the computer. The nurses all had access to the care plans and they were supposed to be updating them as things changes, like falls, and things like that. The DON revealed the care plans were reviewed quarterly and the expectation was the care plans would reflect what was going on with the resident. The DON revealed if the staff missed putting something on the care plane it was expected they would catch it on the quarterly care plan review. The DON confirmed they were a little behind on updating the care plans. Interview with NA-F (Nurse Aide) on 9/22/2020 at 8:57 AM revealed they got the information they needed to care for the residents from the residents' care plans.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09C1c Based on observation, interview, and record review; the facility failed to revise the care plan after falls with new interventions for Resident 4 and Resident 8; failed to document interventions to prevent complications from the use of an indwelling urinary catheter (a tube inserted into and left in the bladder to drain urine) for Resident 6; and failed to implement interventions for a UTI (Urinary Tract Infection) for Resident 21. This affected 4 of 13 sampled residents. The facility identified a census of 21 at the time of survey. Findings are: A. Review of Resident 4's quarterly MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 8/11/2020 revealed an admission date of [DATE]. Resident 4 had a BIMS (Brief Interview for Mental Status) of 5 which indicated severe cognitive impairment. Resident 4 required extensive assistance of 2 staff for bed mobility, transfer, walk in room and corridor, and locomotion on and off unit. Resident 4 had 1 fall with no injury since prior assessment. Observation of Resident 4 on 9/16/20 at 9:50 AM revealed they were walking in the hall without assistance or an assistive device; an unidentified NA got up to Resident 4, held onto Resident 4, and called another staff person for a gait belt and Resident 4's walker. Review of Resident 4's Progress Notes dated 9/16/2020 at 3:14 AM revealed Resident 4 was found lying on the floor on their back next to their bed. A skin tear was observed to Resident 4's right elbow. Resident 4 was assessed and neurological checks were initiated. On 9/16/20 at 2:50 PM it was documented that Resident 4 continued to be anxious and was attempting several times to get up on their own. A call was placed to family to see if a temporary personal alarm would be ok. It was documented the family granted permission for the use of the personal alarm temporarily. Review of Resident 4's Care Plan dated 6/15/2018 revealed no documentation the care plan was revised and a new intervention was implemented after Resident 4 fell on [DATE] including the temporary use of the alarm. B. Review of Resident 6's annual MDS dated [DATE] revealed an admission date of [DATE]. Resident 6 had a BIMS score of 15 which indicated Resident 6 was cognitively intact. Resident 6 required extensive assisting of 2 staff for bed mobility, transfers, and toilet use. Observation of Resident 6 on 9/17/20 at 8:12 AM revealed Resident 6 had an indwelling urinary catheter. Review of Resident 6's Progress Notes dated 8/25/2020 revealed they returned to the facility from the hospital with an indwelling urinary catheter that was to remain in place until Resident 6 was seen by the urologist in September. It was documented the catheter continued to be in place on 8/29/2020 and 9/19/2020. Review of Resident 6's Care Plan dated 9/13/2018 revealed no documentation of the indwelling urinary catheter or interventions to prevent complications from the use of the catheter. C. Review of Resident 8's quarterly MDS dated [DATE] revealed an admission date of [DATE]. Resident 8 had a BIMS score of 12 which indicated moderate cognitive impairment. Resident 8 had 2 or more falls with no injury since prior assessment. Interview with Resident 8 on 09/16/20 at 2:12 PM revealed Resident 8 had a history of [REDACTED]. Review of Resident 8's Care Plan dated 2/4/2020 revealed no documentation of interventions implemented after Resident 8 fell on [DATE]. D. Review of Resident 21's quarterly MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 7/21/2020 revealed an admission date of [DATE]. Resident 21 had a BIMS (Brief Interview for Mental Status) score of 9 which indicated moderate cognitive impairment. Antibiotic medication was administered to Resident 21 on 7 days of the 7 day look back period. Interview with Resident 21's family member on 9/16/20 at 10:37 AM revealed Resident 21 was being treated for [REDACTED]. On 9/11/2020 it was documented that orders were received to discontinue the [MEDICATION NAME] and start [MEDICATION NAME]. Review of Resident 21's MAR (Medication Administration Record) for September 2020 revealed documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAVER CITY MANOR	**P O BOX 70, 905 FLOYD STREET BEAVER CITY, NE 68926**

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 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) the [MEDICATION NAME] Capsule 100 MG (Milligrams) ([MEDICATION NAME] Macro) Give 1 capsule by mouth two times a day for UTI for 10 Days -Start Date-09/02/2020 -D/C (discontinue) Date-09/11/2020 was administered to Resident 21 on 9/2/2020 through 9/11/2020; [MEDICATION NAME] Tablet 500 MG ([MEDICATION NAME]) Give 1 tablet by mouth one time a day for UTI -Start Date-09/12/2020-D/C Date-9/21/2020 was administered to Resident 21 from 9/12/2020 through 9/21/2020 and [MEDICATION NAME] Capsule 500 MG Give 500 mg by mouth two times a day for Urinary Tract Infection -Start Date-10/22/2019 was administered to Resident 21 twice a day from 9/1/2020 to 9/21/2020. Review of Resident 21's Care Plan dated 12/3/2019 revealed no documentation of interventions for the UTI. Interview with the DON (Director of Nursing) on 9/22/2020 at 9:31 revealed the care plans were to be updated in the computer. The nurses all had access to the care plans and they were supposed to be updating them as things changed, like falls, and things like that. The DON revealed the care plans were reviewed quarterly and the expectation was the care plans would reflect what was going on with the resident. The DON revealed if the staff missed putting something on the care plan it was expected they would catch it on the quarterly care plan review. The DON confirmed they were a little behind on updating the care plans. Interview with NA-F (Nurse Aide) on 9/22/2020 at 8:57 AM revealed they got the information they needed to care for the residents from their care plans.
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** LICENSE REFERENCE NUMBER 175 NAC 12-006.10B1 Based on observation, interview, and record review; the facility staff failed to ensure 4 residents (1, 11, 14, 15) were monitored to ensure the resident swallowed their medications during medication administration. This affected 4 of 4 residents observed. The facility census was 21. Findings are: Observation on 09/16/2020 at 08:13 AM in resident (1, 11, 14, 15) rooms, revealed medications sitting on resident's overbed tables, without a nurse or medication aide present to observe the residents swallow their medications. Interview on 9/16/20 at 2:20 PM with LPN-A revealed the residents preferred to take their medications left at bedside; so the residents can take their medications with the resident meals and at their own pace. Observation on 9/22/20 at 08:30 am revealed Resident 11 had cup of medications on an overbed tray and the nurse was not with the resident to observe them taking the medications. Review of Medication Administration: NCLEX-RN, National Council Licensure Examination-Registered Nurse is a nationwide examination of areas to test for to obtain a nursing license revealed the proper procedure for giving oral (by the mouth) medication was to give the patient the medication, Remain with the patient until the medication is swallowed, some patients may pocket (hold) medications in their cheeks rather than swallow them. Medication Administration procedure for the facility revealed for the medication pass #18 remain with the resident until all medications have been taken. Interview with Director of Nursing on 09/22/2020 at 11:00 AM confirmed the nursing staff person who passed the medications should stay with the resident and observe the resident swallow the medications.
F 0727 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.** Licensure Reference Number 175 NAC 12-006.04C1 Based on record review and interview the facility failed to provide 8 hours of RN (Registered Nurse) coverage for every 24 hour period. This had the potential to affect all the residents at the facility. The facility census was 21. Findings are: Record review of the facility nursing staff schedule revealed that the nursing staff schedule did not reflect 8 hours RN coverage for September 20, 2020. Interview on 9/22/2020 at 2:00 PM with the Director of Nursing confirmed there was not any RN coverage on that date in the facility.
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** LICENSURE REFERENCE NUMBER 175 NAC 12-006.12B Based on interview and record review the facility consultant RPh (Registered Pharmacist) failed to identify the irregularity of no monthly INR levels on the chart for Resident 8 and failed to identify that Resident 10 did not have an indicated [DIAGNOSES REDACTED]. The facility identified a census of 21 at the time of survey. A. Review of Resident 8's quarterly MDS dated [DATE] revealed an admission date of [DATE]. Resident 8 had a BIMS score of 12 which indicated moderately impaired cognition. Resident 8 received anticoagulant medication 7 days of the 7 day MDS look back period. Review of Resident 8's Order Summary Report dated 9/21/2020 revealed an order for [REDACTED]. Review of Resident 8's chart, EHR (Electronic Health Record) and progress notes revealed no documentation of and INR being completed for July or August 2020. Review of Resident 8's lab reports revealed no documentation an INR had been completed June of 2020. Interview with LPN-E (Licensed Practical Nurse) on 9/22/2020 at 11:35 AM revealed they were unable to locate documentation the INR had been completed for Resident 8 in July or August 2020. LPN-E revealed they would have to contact the lab and/or the clinic to see if the INR had been done in July and August 2020. Review of Resident 8's Pharmacist Drug Regimen Review dated 7/28/2020 and 8/28/2020 revealed no documentation the consultant RPh identified Resident 8's medical record contained no documentation an INR had been checked in July and August 2020. Resident 8's September INR was in a folder at the nurses' station awaiting return correspondence from the medical provider as it had been faxed to the clinic. Interview with the facility Administrator on 9/22/20 at 11:36 AM revealed the review of lab results was part of the Medication Regimen Review process. Interview with the DON (Director of Nursing) on 9/22/20 at 11:43 AM confirmed the pharmacist should be identifying if the labs were getting done. The DON revealed they used to get a sheet from the consultant pharmacist about missed labs but they hadn't gotten one for quite a while. Interview with LPN-E on 9/22/20 at 11:53 AM revealed they had contacted the nurse at the medical clinic and Resident 8 had an INR checked July 29. LPN-E revealed they had requested the clinic nurse send a copy to the facility as it was not in Resident 8's medical record. LPN-E confirmed they should be getting the results from the clinic. LPN-E confirmed there had been no INR checked in August, but it was checked 7/29/2020 and 9/4/2020, 37 days apart. Review of the facility policy Medication Regimen Review dated 3/24/2017 revealed the following: Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident with the foal of promoting positive outcomes and minimizing adverse consequences associate with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. The review must include a review of the resident' medical chart. The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and the reports must be acted upon. B. Review of Resident 10's physician's orders revealed the resident was admitted to the facility from the hospital on [DATE] and was on a new medication, [MEDICATION NAME] (antipsychotic-medication used to treat behavior disorders) routinely without a diagnosis, or signs and symptoms to obseve or monitor. Review of Resident 10's Monthly Medication Regimen Review from 02/25/20 thru 09/11/20 revealed the Registered Pharmacists documentation for these months stated medications records were reviewed and no further action needed on an 8 by 11 sheet of paper. Interview with the DON on 09/17/20 at 09:20 AM revealed the MRR (Monthly Medication Regimen Review) prepared by their Pharmacist, was on the sheet of paper in the residents hard chart. The DON revealed the DON was not aware the pharmacist should communicate on a PAR (Physician Action Report) any items needed for review of medications, lab work, or to decreasing the dose of medications; to have communications with the Physician and alerting the provider of any concerns or recommendations. The DON confirmed the Pharmacist did not communicate the nursing staff recommendations or concerns.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D Based on interview and record review, the facility failed to fax BP (Blood Pressure) readings to the provider as ordered after medication dosages were changed for Resident 4. This affected 1 of 7 sampled residents. The facility identified a census of 21 at the time of survey. Findings are: Review of Resident 4's of quarterly MDS dated [DATE] revealed an admission date of [DATE]. Resident 4 had a BIMS (Brief Interview for Mental Status) score of 5 which indicated severe cognitive impairment. Resident 4 required extensive assistance of 2 staff for bed mobility, transfer, walk in room and corridor, locomotion on and off unit, and toilet use. Active [DIAGNOSES REDACTED]. Review of Resident 4's Order Summary Report dated 9/17/2020 revealed orders for the following: [MEDICATION NAME] (blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAVER CITY MANOR	P O BOX 70, 905 FLOYD STREET BEAVER CITY, NE 68926

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 0757 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) pressure medication) Tablet 25 MG Give 1 tablet by mouth in the morning related to essential (primary) hypertension (high blood pressure) with an active date of 11/28/2017 and [MEDICATION NAME] (blood pressure medication) Tablet 5 MG Give 1 tablet by mouth in the morning related to essential (primary) hypertension with an active date of 8/20/2020. Review of Resident 4's Weights and Vitals Summary report dated 9/21/2020 revealed the following blood pressure readings: 09/18/2020 07:53 106/58 mmHg Diastolic Low of 60 exceeded (bottom number is low-an abnormal finding) 09/17/2020 15:47 97/53 mmHg Diastolic Low of 60 exceeded 09/17/2020 09:00 132/43 mmHg Diastolic Low of 60 exceeded 09/16/2020 08:04 152/69 mmHg 09/09/2020 10:01 126/52 mmHg Diastolic Low of 60 exceeded 09/04/2020 14:28 150/68 mmHg 09/03/2020 09:52 105/47 mmHg Diastolic Low of 60 exceeded 09/02/2020 21:46 106/48 mmHg Diastolic Low of 60 exceeded 09/02/2020 09:56 152/50 mmHg Diastolic Low of 60 exceeded 09/02/2020 02:17 100/54 mmHg Diastolic Low of 60 exceeded 09/02/2020 02:00 100/54 mmHg Diastolic Low of 60 exceeded 09/01/2020 10:30 120/68 mmHg 09/01/2020 02:22 98/61 mmHg 08/31/2020 14:52 110/59 mmHg Diastolic Low of 60 exceeded 08/30/2020 19:10 118/66 mmHg 08/30/2020 09:36 118/70 mmHg 08/29/2020 19:21 131/59 mmHg Diastolic Low of 60 exceeded 08/29/2020 09:21 114/56 mmHg Diastolic Low of 60 exceeded 08/28/2020 22:57 116/46 mmHg Diastolic Low of 60 exceeded 08/28/2020 13:50 141/67 mmHg 08/28/2020 11:05 141/67 mmHg 08/27/2020 22:00 100/37 mmHg Diastolic Low of 60 exceeded 08/27/2020 21:24 100/37 mmHg Diastolic Low of 60 exceeded 08/27/2020 09:47 98/56 mmHg Diastolic Low of 60 exceeded 08/26/2020 19:49 116/56 mmHg Diastolic Low of 60 exceeded 08/26/2020 09:43 114/64 mmHg 08/25/2020 22:47 107/54 mmHg Diastolic Low of 60 exceeded 08/25/2020 11:35 104/72 mmHg 08/25/2020 09:39 104/72 mmHg 08/24/2020 20:02 107/40 mmHg Diastolic Low of 60 exceeded 08/24/2020 10:13 139/48 mmHg Diastolic Low of 60 exceeded 08/23/2020 19:05 108/68 mmHg 08/23/2020 10:27 93/48 mmHg Diastolic Low of 60 exceeded 08/22/2020 19:04 120/74 mmHg 08/22/2020 11:08 122/46 mmHg Diastolic Low of 60 exceeded 08/21/2020 19:02 112/78 mmHg 08/21/2020 16:17 127/67 mmHg 08/21/2020 10:17 113/54 mmHg Diastolic Low of 60 exceeded 08/20/2020 21:37 120/60 mmHg 08/20/2020 20:28 120/60 mmHg 08/20/2020 10:19 118/81 mmHg Review of Resident 4's MAR (Medication Administration Record) for September 2020 revealed documentation Resident 4 received the following medications: [REDACTED]. Resident 8 also had an order on the September 2020 MAR to check blood pressure for 2 weeks BID (twice a day) then weekly. Fax Dr. on 9/03/2020 with a Start Date of 8/20/2020. Review of Resident 4's Physician's Appointment Sheet dated 8/20/2020 revealed the following order signed by the medical provider: decrease [MEDICATION NAME] to 5 mg daily. Fax BP's in 2 weeks. Check daily BP's for 2 weeks then routine. Review of Resident 4's Progress Notes revealed no documentation the medical provider was faxed or notified about the blood pressure readings. Interview with the DON (Director of Nursing) on 9/22/20 at 10:55 AM confirmed there was no documentation the blood pressures readings were faxed the medical provider. The DON confirmed if the nursing staff didn't document it, they probably didn't do it. The DON revealed the appointment on 8/20/2020 was an onsite visit and the Dr. only came to the facility every other month so the Dr. would not have been here since 8/20/2020 to notify them about the BP readings yet. Interview with LPN-E (Licensed Practical Nurse) on 9/22/2020 at 11:03 AM revealed they had checked the MAR and it was a medication aide who had checked the blood pressures and they probably didn't notify the charge nurse the blood pressures needed to be faxed to the Dr. and they should have followed through with the order.
F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** LICENSURE REFERENCE NUMBER 175 NAC 12-006.11E Based on observation, interview, and record review; the facility staff failed to store food containers in a manner to prevent potential cross contamination and failed to serve drinks to prevent potential cross contamination. This had the potential to affect all of the facility residents. The facility identified a census of 21 at the time of survey. Findings are: Interview with the facility Administrator on 09/16/20 8:15 AM revealed all of the facility residents were being served their meals on disposable dishes and containers in their rooms. A. Observation of the kitchen on 9/16/2020 at 8:20 AM revealed Cook-D was dishing food into square Styrofoam containers and pouring cereal into Styrofoam bowls. The square Styrofoam containers and Styrofoam bowls. DA-H (Dietary Aide) then took the containers on a cart out to the residents. DA-H took a square container into each residents' room and the residents were observed eating food from the containers. Observation of the kitchen on 9/16/2020 at 12:06 PM revealed Cook-D dished food into square Styrofoam containers. DA-H then took the containers of food to the facility residents. The square Styrofoam containers and Styrofoam bowls were sitting on the floor in a bag. DA-H took a square container into each residents' room and the residents were observed eating food from the containers. Interview with the FSS (Food Service Supervisor) on 9/22/2020 at 9:05 AM revealed the Styrofoam box containers and the bowls were not to be stored on the floor. Review of the facility policy Sanitation and Infection Control effective March 23, 2017 revealed the following: It is the policy of this facility that Dietary Employees follow all areas of sanitation and infection control as stated is USFDA Food Code 2013. Employees will practice good personal hygiene to be in compliance with infection control. All employees are to follow use of gloves and handwashing policy. B. Observation on 09/16/2020 at 12:15 PM residents were eating meals in their rooms, the dietary staff brought out drinks for the residents on a three tiered cart. The dietary staff provided drinks for all residents, no hand hygiene was observed as the dietary staff went up and down each hallway, pouring drinks and moving personal items on the residents' over bed tables. Observation on 09/22/20 at 08:05 AM revealed the nursing and dietary staff were delivering breakfast trays, from one to another resident without hand hygiene between setting residents up with their meals. A bottle of hand sanitizer liquid was on the top of the cart that held the residents food. On 09/22/2020 at 09:07 AM interview with the Food Service Supervisor revealed their expectation was the staff did not need to sanitize their hands if they were just delivering food to the residents. Record review of undated facility policy on Handwashing revealed the following: Employees will use proper handwashing techniques that will aid in the prevention of the transmission of infection. Guidelines When to Wash Hands: whenever hands are obviously soiled.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.17B LICENSURE REFERENCE NUMBER 175 NAC 12-006.17D Based on observation, interview, and record review; the facility staff failed to prevent potential cross contamination by failing to perform hand hygiene during meal preparation and during meal service which affected all of the facility residents; failed to prevent potential cross contamination by failing to change gloves and perform hand hygiene during cares which affected 1 sampled resident (Resident 21);failed to prevent potential cross contamination by failing to clean the lift after use which had the potential to affect all of the residents who used the lifts (Residents 21, 6, 22, 20, 14, 13 and 24) ; failed to prevent potential cross contamination by failing to store an indwelling catheter bag off the floor for 1 of 2 residents with a catheter (Resident 6); and failed to prevent potential cross contamination by failing to perform hand hygiene during a dressing change for 1 of 3 sampled residents (Resident 6). The facility identified a census of 21 at the time of survey. Findings are: A. Observation of the facility kitchen on 9/16/2020 at 8:20 AM revealed Cook-D putting food into square Styrofoam containers. DA-H (Dietary Aide) then took the boxes out into the halls on a cart to the residents who were dining in their rooms. DA-H took food to Resident 14 in their room then to Resident 10; then to Resident 9; then took food to Resident 2 by handling the Styrofoam containers and placing them in front of the residents. DA-H touched Resident 2's Styrofoam cup to move it as it was sitting on the tray table and then DA-H sat the container of food in front of Resident 2. DA-H did not do hand hygiene between residents or when they touched Resident 2's cup. At 8:37 AM DA-H took the cart back to kitchen area and picked up 3 more food boxes. DA-H did not do any hand hygiene. DA-H then took food to Resident 12, Resident 3, and Resident 11. DA-H then pushed the cart back to the kitchen and touched the rims of Styrofoam coffee cups then put coffee in them from an urn with a spigot. DA-H then put creamer in one of them the put lids on both of the cups. At 8:43 AM DA-H took the coffee to Resident 8 and Resident 22. DA-H did not do any hand hygiene. All of the residents were observed feeding themselves and handling the cups and food. Resident 2 was observed drinking from the glass DA-H touched then did not perform hand hygiene prior to serving food to the other residents. Observation of the facility kitchen on 9/16/2020 at 9:48 AM revealed Cook-D washed their hands at the sink. After Cook-D washed their hands, they turned the water off with their bare hand then got paper towels and dried their hands. Cook-D then poured tater tots into 2 pans. Cook-D then poured diced chicken onto the tater tots. Cook-D then placed peas and carrots onto the tater tots and chicken then poured milk and cream of chicken soup mixture over all. Cook-D then put foil on the pans and placed them into the oven.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. BUILDING _____ B. WING _____	09/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAVER CITY MANOR	P O BOX 70, 905 FLOYD STREET BEAVER CITY, NE 68926

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 4) Cook-D touched the food prep items in the kitchen and used their un-gloved hands which they had touched the faucet with to prepare the foods. Observation of the facility kitchen on 9/16/2020 at 11:53 AM revealed Cook-D washed their hands. Cook-D shut the faucet off with their bare hand then dried their hands with paper towels. Cook-D then prepared pureed food in a blender for Resident 17 then placed it into a square Styrofoam container. At 12:06 PM, Cook-D then dished the regular food for the other facility residents into the square Styrofoam containers. Cook-D had bare hands and handled the containers while filling them with food. DA-H then took the food to the facility residents. The residents were observed eating the food from the Styrofoam containers. B. Observation of the facility on 9/17/20 at 8:12 AM revealed DA-H took a cart with square Styrofoam containers down the hall. DA-H took the food boxes into each residents room. DA-H did not perform any hand hygiene after DA-H took the food boxes in to each resident. DA-H was directly observed taking food to Resident 22, Resident 13, Resident 5, Resident 16, Resident 14, Resident 19, and Resident 8. The residents were observed eating the food from the Styrofoam containers. Interview the FSS (Food Service Supervisor) on 9/22/2020 at 9:05 AM if the dietary staff touched the tables or the glasses/cups, they were supposed to do hand hygiene. The FSS expressed they did not realize the staff had to do hand hygiene between each resident but the FSS agreed they probably should since the DA was taking food in to residents who were not always wearing a mask and there was potential for cross contamination as the DA was in close proximity to the residents when they were delivering the food containers. The FSS revealed the staff were not supposed to touch the handles on the faucets with their bare hands after they had washed their hands; they were supposed to get the towel, dry their hands, then use a towel to shut the faucet off and also use a towel to open the door. Review of the undated facility policy Handwashing revealed the following: Employees will use proper handwashing techniques that will aid in the prevention of the transmission of infection. Guidelines When to Wash Hands: whenever hands are obviously soiled. Before preparing or handling food or medications. After handling items or work surfaces potentially contaminated with blood, excretions, or secretions. Whenever in doubt. C. Observation of Resident 21 on 9/21/20 at 2:35 PM revealed the following: MA-B (Medication Aide) and MA-C assisted Resident 21 with peri care. MA-B and MA-C both donned gloves. MA-B lowered Resident 21's brief and Resident 21 started to urinate so MA-C pulled the brief back up to cover Resident 21. MA-C then pulled the brief back down then touched Resident 21's clothing and face and asked Resident 21 to roll over. MA-C touched Resident 21's clothing and face wearing the same gloves MA-C was wearing when they had touched Resident 21's brief. MA-B did not have wipes so MA-B touched the lift with the gloved hands MA-B had touched Resident 21's clothing and brief with and moved the lift so MA-B could get to the bathroom to get wipe. MA-B then got the wipes out of the bathroom and returned to Resident 21's bedside. MA-B then used pre-moistened wipes to wipe Resident 21's perineum (bottom). MA-B removed the soiled brief and discarded it into the trash then MA-B then used the same gloved hands and put clean brief under Resident 21. MA-B then removed their gloves. MA-B did not do hand hygiene after they removed the gloves. MA-C then fastened the brief. MA-B and MA-C then handled Resident 21's blanket and covered Resident 21 with it. MA-C then removed the gloves and then used their bare hands to take Resident 21's shoes off. MA-C then handled the oxygen tubing and cannula (the tube used to administer oxygen into the nose) and placed it on Resident 21's face. MA-C had not done hand hygiene after MA-C removed the gloves and handled Resident 21's shoes. MA-C then went and washed their hands. MA-B pulled the trash bag out of the can with the soiled brief and wipes in it and used both hands to tie it. MA-B was holding it in their hand. MA-B then took the call light box off of Resident 21's rolling table then gave Resident 21 their call light box. MA-B opened the door by grabbing the handle and took the lift out and the trash bag out of the room. MA-B put the trash in the utility room then came back out and used hand sanitizer to do hand hygiene. MA-C put the lift back into the store room and did not clean it. MA-C then left the store room and did hand hygiene with hand sanitizer. 1 full lift in the store room was placed between 2 sit to stand lifts. Interview with LPN-E (Licensed Practical Nurse) on 9/22/20 at 10:18 AM revealed these resident used the facility lifts: Resident 22, Resident 6, Resident 14, Resident 20, Resident 21, and Resident 24 used the full lift. Resident 13 and Resident 24 used the sit to stand lift. LPN-E revealed Resident 24 used both lifts. D. Review of Resident 6's annual MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 8/11/2020 revealed an admission date of [DATE]. Resident 6 had a BIMS (Brief Interview for Mental Status) score of 15 which indicated Resident 6 was cognitively intact. Resident 6 required extensive assistance of 2 staff for bed mobility, transfer, and toilet use. Resident 6 had a pressure ulcer/injury Stage 3 unhealed pressure ulcer not present upon admission. Pressure reducing device for chair or bed, pressure ulcer/injury care and application of non-surgical dressings (with or without topical medications) other than to feet were used. Interview with Resident 6 on 9/16/20 at 3:21 PM revealed they had a pressure ulcer on their coccyx (tailbone). Observation of Resident 6 on 9/17/20 at 8:12 AM revealed Resident 6 was in bed. Resident 6 had an indwelling urinary catheter (a tube inserted into and left in the bladder to drain urine). The catheter bag was uncovered and lying on the floor. Observation of Resident 6 on 9/17/20 at 2:24 PM revealed Resident 6 was in bed. Resident 6's catheter bag was uncovered and lying on the floor. Observation of Resident 6 on 9/21/2020 at 10:56 AM revealed LPN-A (Licensed Practical Nurse) and LPN-G completing a dressing change for Resident 6. LPN-A and LPN-G washed their hands and donned gloves. At 11:00 AM LPN-A picked the trash can up with the gloved hand and moved it closer to the work area. LPN-A then removed their gloves and put new gloves on. LPN-A did not do hand hygiene after between glove changes. LPN-A helped Resident 6 roll over in bed by touching Resident 6's skin and clothing. LPN-A revealed the old dressing had already been removed as Resident 6 had gotten a bath. The area to coccyx was observed to be about a cm in diameter and was a Stage III (Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed). Using the same gloved hands, LPN-A cleaned the open area with wound wash and a gauze pad and discarded the gauze pad into the trash can. Resident 6 had stooled so LPN-A cleaned that with a cleansing wipe then discarded it into the trash can. LPN-A changed gloves but did not perform hand hygiene. LPN-A put gel into the wound using their gloved finger then applied skin prep to the area around the wound. LPN-A put a gauze pad into the wound and placed an adhesive bordered dressing over the gauze pad. LPN-A removed their gloves and washed their hands. At 11:06 AM LPN-A touched the trash can and picked it up so Resident 6 could discard something into the trash can. LPN-A put the trash can back on the floor, put the table close to Resident 6, then picked up Resident 6's cell phone off the bedside stand and handed it to Resident 6. LPN-A then picked up the tub of supplies then touched the door knob to open it and left the room. LPN-A then opened the medication room door with the same hands and took the tub of Resident 6's dressing supplies into the medication room. LPN-A did not do hand hygiene after handling the trash can before handling Resident 6's personal items and touching the table and the door knobs. Interview with NA-F (Nurse Aide) on 9/22/2020 at 8:57 AM revealed the staff were expected to make sure the catheter bags were not lying on the floor. Interview with the DON (Director of Nursing) on 9/22/2020 at 9:31 AM revealed the staff were expected to perform hand hygiene between residents; when the staff were switching cares from one task to another and when the gloves were contaminated they were expected to change their gloves. The staff person would be expected to do hand hygiene after they touched the dirty trash can. It was the expectation the staff would change their gloves and be prepared and have their supplies ready so they didn't have opportunities to contaminate the gloves. The staff were expected to clean the lifts between residents. The DON confirmed the facility lifts were used for multiple residents. Review of the undated facility policy Use of Gloves revealed the following: Gloves must never be used in place of hand washing. Gloves should be changed: as soon as they become soiled or torn; before beginning a different task. Review of the undated facility policy Mechanical Lift Cleaning revealed the following: Mechanical Lift devices will be cleaned after each usage with the germicidal wipes utilized by the facility. The mechanical lift will not be used on another resident until the recommended time frame has elapsed for the maximal effect of the germicidal cleansing wipes. Review of the undated facility policy Catheter Care revealed the following: Check the following items: Catheter is not lying on floor. Review of the undated facility policy Handwashing revealed the following: Employees will use proper handwashing techniques that will aid in the prevention of the transmission of infection. Guidelines When to Wash Hands: Whenever hands are obviously soiled. After handling used dressings, specimen containers, contaminated tissues, linen, etc. After contact with blood, oral secretions, mucous membranes, broken skin, etc. After handling items or work surfaces potentially contaminated with blood, excretions, or secretions. Whenever in doubt. E. Observation on 09/16/20 at 08:10 AM revealed MA-B observed taking the cart down 100 with the food boxes for resident meals. MA-B took the food boxes into each resident's room on 100 and did not perform any hand hygiene; MA-B was directly observed taking food to Resident 1, Resident 13, Resident 15, and Resident 16. MA-B went into each room, moving and helping get over bed tray clear for meals, no hand hygiene was performed. On 09/22/20 at 11:36 AM an interview with the Director of Nursing revealed expectations of all staff would be to use hand hygiene before, between and after each tray passed to residents. Record review of undated facility policy on Handwashing revealed the following: Employees will use proper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285269	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAVER CITY MANOR	**P O BOX 70, 905 FLOYD STREET BEAVER CITY, NE 68926**

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 5) handwashing techniques that will aid in the prevention of the transmission of infection. Guidelines When to Wash Hands: whenever hands are obviously soiled.
F 0881 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement a program that monitors antibiotic use.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility staff failed to identify the use of multiple antibiotics for 1 of 7 sampled residents (Resident 21) placing the resident at risk for complications of antibiotic use. The facility identified a census of 21 at the time of survey. Findings are: Review of Resident 21's quarterly MDS (Minimum Data Set-a comprehensive assessment tool used to develop a resident's care plan) dated 7/21/2020 revealed an admission date of [DATE]. Resident 21 had a BIMS (Brief Interview for Mental Status) score of 9 which indicated moderate cognitive impairment. Antibiotic medication was administered to Resident 21 on 7 days of the 7 day look back period. Interview with Resident 21's family member on 9/16/20 at 10:37 AM revealed Resident 21 was being treated for [REDACTED]. Review of Resident 21's Order Summary Report dated 9/21/2020 revealed an order for [REDACTED]. On 9/11/2020 it was documented that orders were received to discontinue the [MEDICATION NAME] and start [MEDICATION NAME]. There was no documentation in Resident 21's Progress Notes that the medical provider had been contacted regarding whether to hold the [MEDICATION NAME] prior to the administration of the [MEDICATION NAME] and the [MEDICATION NAME]. Review of Resident 21's MAR (Medication Administration Record) for September 2020 revealed documentation the [MEDICATION NAME] Capsule 100 MG (Milligrams) ([MEDICATION NAME] Macro) Give 1 capsule by mouth two times a day for UTI for 10 Days Start Date 09/02/2020 D/C (Discontinue) Date 09/11/2020 was administered to Resident 21 on 9/2/2020 through 9/11/2020; [MEDICATION NAME] Tablet 500 MG ([MEDICATION NAME]) Give 1 tablet by mouth one time a day for UTI -Start Date-09/12/2020-D/C Date-9/21/2020 was administered to Resident 21 from 9/12/2020 through 9/21/2020 and [MEDICATION NAME] Capsule 500 MG Give 500 mg by mouth two times a day for Urinary Tract Infection -Start Date-10/22/2019 was administered to Resident 21 twice a day from 9/1/2020 to 9/21/2020. Resident 21 received 3 different antibiotics in the time frame from 9/2/2020 to 9/21/2020 and received both [MEDICATION NAME] and [MEDICATION NAME] concurrently with the [MEDICATION NAME]. Review of Resident 21's Bacteria Culture Results dated 9/5/2020 revealed the medical provider wrote the order to change (antibiotic) to [MEDICATION NAME] 500 mg PO (by mouth) Daily for 10 days. Interview with the DON (Director of Nursing) on 9/22/2020 at 9:31 AM revealed the facility staff had not contacted the medical provider to determine if the Keflex should be put on hold or continued while Resident 21 was being treated with the [MEDICATION NAME] and [MEDICATION NAME] for the acute UTI.