

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285062	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/26/2025
NAME OF PROVIDER OR SUPPLIER Midwest Covenant Home		STREET ADDRESS, CITY, STATE, ZIP CODE 615 East 9th Street Stromsburg, NE 68666	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175NAC 12-006.02(H)</p> <p>Based on record review and interview the facility failed to submit a written investigation for alleged abuse to the state agency within 5 working days as required for 2 of 3 residents (Residents 12 and 19). The facility census was 38.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of the undated facility policy titled Abuse Neglect and Misappropriation of Property Policy revealed that the facility supports a zero tolerance for resident abuse, neglect, and/or misappropriation of property. The definition of physical abuse includes hitting, slapping, pinching, and kicking. The section titled Resident to Resident Abuse revealed that staff must intervene to protect the residents and separate the individuals immediately. In all cases of alleged abuse, neglect, or misappropriation/exploitation of resident property the role of the facility is to intervene in the situation; report the situation to the proper authorities; investigate the allegation; prevent abuse while the investigation is in process; and have documented evidence that the facility intervened, reported, prevented, and investigated. The facility must ensure that all alleged violations are reported immediately to the administrator of the facility and to other officials in accordance with State Law. A facility investigation report form will be filled out and sent/faxed within 5 working days to: Health Facility Investigations (the State Agency).</p> <p>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 12 dated 1/29/25 revealed that Resident 12 admitted into the facility on [DATE]. Resident 12 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 3 indicating severely impaired cognition. Resident 12 requires maximal assistance (the staff does more than half the effort) for personal hygiene, toileting and transferring. Resident 12 is frequently incontinent of bladder (urine) and occasionally incontinent of bowel (stool).</p> <p>Record review of the progress note dated 9/4/24 at 8:31 AM for Resident 12 revealed that Resident 12 was in the dining room. The tablemate of Resident 12 spilled their eggs and Resident 12 attempted to assist the tablemate with cleaning up the eggs. The tablemate balled their fist and hit Resident 12 on the forearm. The Director of Nursing, Facility Administrator, and Social Services Director were informed of the resident to resident incident.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 285062
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the progress note dated 9/4/24 at 12:41 PM for Resident 12 revealed that the facility contacted Adult Protective Services (APS) (the State of Nebraska agency designated for receiving reports of abuse, neglect, or exploitation) to file the report of the resident to resident incident.</p> <p>Record review of the medical record of Resident 12 revealed no documentation that a written investigation of the 9/4/24 resident to resident incident was completed and submitted to the state agency.</p> <p>Interview on 3/26/25 at 2:27 PM with the Facility Administrator (FA) confirmed that the 9/4/24 resident to resident incident had been reported to APS as alleged resident to resident abuse.</p> <p>Interview on 3/26/25 at 2:39 PM with the facility Director of Nursing (DON) confirmed that the resident to resident incident directed towards Resident 12 occurred on 9/4/24 and was reported to APS. The DON revealed that the resident that hit Resident 12 was moved to a different table. The DON confirmed that the facility did not submit the written investigation to the state agency as required.</p> <p>B.</p> <p>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 19 dated 2/12/25 revealed that Resident 19 admitted into the facility on 2/15/21. Resident 19 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 3 indicating severely impaired cognition. Resident 19 is dependent on staff for personal hygiene and bathing. Resident 19 requires maximal assistance (the staff does more than half the effort) for toileting and transferring. Resident 19 is frequently incontinent of bowel (stool) and bladder (urine).</p> <p>Record review of the progress note dated 12/18/24 at 3:26 PM revealed that a nurse aide went to help Resident 19 with cares last evening (12/17/24). Resident 19 became agitated and combative. The nurse aide grabbed the arms of Resident 19 and held them near the resident's chest. The licensed nurse intervened and the Director of Nursing (DON) was called.</p> <p>Record review of the Adult Protective Services Intake Worksheet dated 12/19/24 revealed that APS was notified of the physical abuse on 12/18/24 at 5:14 PM. The worksheet revealed that on 12/17/24 the nurse aide went to provide care for Resident 19. Resident 19 declined and requested to continue watching television in the gathering area. The nurse aide tried to forcibly move Resident 19 from the gathering area by grasping the resident's arms and putting them across the resident's chest while Resident 19 was in the wheelchair. Another staff saw this and immediately intervened.</p> <p>Record review of the medical record of Resident 19 revealed no documentation that a written investigation of the 12/17/24 staff to resident incident was completed and submitted to the state agency.</p> <p>Interview on 3/26/25 at 2:27 PM with the Facility Administrator (FA) confirmed that the 12/17/24 staff to resident incident had been reported to APS.</p> <p>Interview on 3/26/25 at 2:39 PM with the facility Director of Nursing (DON) confirmed that the DON was notified of the staff to resident incident on 12/17/24 and came to the facility. The DON revealed that the staff member involved was agency staff and the DON escorted the staff member out of the building. The DON revealed that that staff member was not allowed to return to work in the facility.</p> <p>(continued on next page)</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 3/26/25 at 4:22 PM with the DON confirmed that the facility completed an Incident Investigation Report (a written investigation) dated 12/18/24. The DON confirmed that the investigation report was not submitted to the state agency as required.		