STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285073	A. Building B. Wing	01/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Haven Nursing Home	309 North Madison Street Coleridge, NE 68727

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview: the facility failed to report an allegation of potential abuse and/or neglect to the State Agency, to complete an investigation and submit the results of the investigation for 1 (Resident 8) of 2 sampled residents. The facility census was 29. Findings are: A. Review of the facility Abuse/Neglect/Exploitation Policy (undated) indicated the following: -failure to provide supervision (care and control of a vulnerable adult which a reasonable and prudent person could exercise under similar facts and circumstances) was one definition of abuse. -the facility was to report any alleged abuse/neglect, injuries of unknown origin, or misappropriation of resident property in accordance with state regulations. -the facility was to conduct an investigation of such allegations in accordance with state law. -the facility was to report all investigation findings to the state in accordance with state regulations. B. Review of Resident 8's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 11/1/24 revealed the resident was admitted [DATE] with diagnoses of multiple sclerosis, diabetes, heart disease, depression, and Alzheimer's disease. The resident's cognition was intact, and the resident required substantial to maximal assistance with toileting hygiene, bed mobility, transfers, and dressing. Review of Resident 8's current Care Plan (undated) revealed the resident had a self-care deficit related to multiple sclerosis and indicated the resident's wheelchair was the resident's primary means of locomotion. The resident required staff assistance at times with wheelchair mobility except for short distances. In addition, the resident had impaired though processes due to occasional forgetfulness related to Alzheimer's disease. Review of a Nursing Progress Note dated 8/22/24 at 5:39 PM revealed the staff were assisting the resident with wheelchair mobility out to the facility van for an activity. Staff positioned the resident's wheelchair next to the van ramp and then turned to talk to another staff member. As staff (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	turned back to the resident, they observed the resident's wheelchair rolling down the sloped parking lot. The front wheel of the chair struck the curb, and the resident was launched out of the wheelchair into the grass and landed on the resident's stomach with arms outstretched. An assessment of the resident revealed no injuries. Review of the facility investigations of potential abuse/neglect from 1/22/24 to 1/22/25 revealed no report had been filed to the State Agency regarding a potential allegation of staff to resident abuse and/or neglect related to Resident 8. During an interview on 1/27/25 at 2:55 PM, the facility Administrator, and Licensed Practical Nurse (LPN)-C confirmed the facility failed to report the incident with Resident 8 which occurred 8/22/24. An investigation was not completed, and the results of the investigation were not submitted to the State Agency within the required time. The Administrator further indicated the facility should have reported and investigated the incident to rule out potential abuse and/or neglect.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(I)(i). Based on record review and interview; the facility failed to identify causal factors and to revise and/or develop additional interventions for the prevention of ongoing falls and a fall with a significant injury for Resident 78. The sample size was 7 and the facility census was 29. Findings are: A. Review of the facility Fall Prevention and Management Program with a revision date of 8/23/24 revealed the purpose of the policy was to develop, implement, monitor, and evaluate the prevention and the management of falls. Fall prevention included the determination of a resident's risk for falls. The staff were to develop fall prevention interventions based on the resident's risk factors. If interventions were not effective in reducing falls, then new interventions were to be initiated. If a resident had a fall staff were to follow the following procedure: -complete head-to-toe assessment. -notify the attending physician of the fall, interventions, and the status of the resident. -complete a risk management for falls. -complete a fall huddle. -communicate to all staff the resident had a fall and share details regarding interventions initiated. -conduct an interdisciplinary conference to determine cause of falls and develop changes to prevent reoccurrence. B. Review of Resident 78's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 12/16/24 revealed the resident was admitted [DATE] with diagnoses non-Alzheimer's dementia, non-traumatic brain dysfunction, and previous stroke. The assessment further indicated the following regarding Resident 78: -severe cognitive impairment. -required partial to moderate staff assistance with personal hygiene, dressing, bed mobility and transfers. -behaviors which included physical/verbal behaviors directed at others, other behavioral symptoms not directed at others, rejection of cares and wandering. The resident's wandering placed the resident at significant risk of getting to a potentially dangerous place. -incontinence of bladder. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-experienced 1 fall without injury since admission but had a history of falls prior to admission. Review of a Nursing Progress Notes revealed the following: -12/9/24 at 3:08 PM the resident was admitted to the facility due to wandering with an order for Seroquel 50 milligrams (mg) at bedtime. -12/9/24 at 6:02 PM the resident had an elopement from the facility. -12/10/24 at 8:46 PM the resident continued to wander but was easily redirected by staff. Review of a facility Incident Report dated 12/11/24 at 10:00 PM revealed the resident had fall in the resident's room. A new intervention was developed for a sensor alarm (an electronic pressure sensitive sensor pad designed for use in chairs or beds which will alarm if a resident tries to get up without assistance) to be placed on the resident's bed and for the staff to check on the resident every 15 to 20 minutes to ensure safety. The resident was confused, drowsy and identified as a wanderer. Review of Nursing Progress Notes on 12/12/24 at 12:37 PM, 12/13/24 at 2:14 AM, at 5:44 AM and at 3:15 PM revealed the resident was wandering and exit seeking. Review of a Nursing Progress Note dated 12/13/24 at 3:22 PM revealed a new order was received for Seroquel (medication used to treat schizophrenia and bipolar disorder) 50 milligrams (mg) twice a day due to the resident's agitated and aggressive behaviors. In addition, a new order was received for Trazodone (medication used to treat depression) 50 mg at bedtime for insomnia. A camera was placed in the resident's room with the monitor at the Nurse's station so staff would be able to observe the resident while in the resident's room. Review of Nursing Progress Notes on 12/14/24 at 4:13 PM and at 4:24 PM the resident was wandering and was combative with staff. Review of a Nursing Progress Note dated 12/14/24 at 10:00 PM revealed a new order for Haldol (medication used to treat certain mental and neurological disorders) 0.5 mg intramuscular (IM) every 30 minutes as needed not to exceed 2 mg in 24 hours after a resident-to-resident altercation. Resident 78 was given 2 doses before the resident had calmed and agitation decreased. Review of a Nursing Progress Note dated 12/16/24 at 5:54 PM revealed a new order for Clonazepam (medication used to prevent and treat anxiety disorders, seizures, and bipolar mania) 0.5 mg twice a day due to increased behaviors and agitation. In addition, a motion sensor alarm (electronic device that uses a sensor to detect nearby people or objects) was placed in the resident's room that alarmed at the Nurse's station to alert staff to the resident's movements. Review of a facility Incident Report dated 12/16/24 at 9:00 PM revealed Resident 78 had another resident-to-resident altercation and was given Haldol 0.5 mg IM due to behaviors. Review of a Nursing Progress Note dated 12/18/24 at 5:42 AM revealed the resident had received the first dose of the Clonazepam the previous evening. Review of an Incident Report dated 12/18/24 at 11:30 AM revealed the resident fell against the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	wall. Review of the resident's electronic medical record revealed no evidence causal factors were assessed, current interventions were revised, or a new intervention was developed. Review of a Nursing Progress Note dated 12/18/24 at 3:45 PM revealed a new order to discontinue current order for Haldol and to start Haldol 1 mg IM every 6 hours as needed for agitation and aggression. Review of a Nursing Progress Note dated 12/19/24 at 3:02 PM revealed the Charge Nurse removed the pressure alarm to the resident's bed as the noise increased the resident's level of agitation. Review of a Nursing Progress Note dated 12/19/24 at 5:15 PM revealed staff had to provide repeated instructions regarding use of the walker as the resident was sleepier and more confused. Review of an Incident Report dated 12/19/24 at 8:40 PM revealed the staff heard the resident calling out for help and the resident was found on the floor of the resident's room. The resident was encouraged to use the resident's walker despite the resident's severe cognitive impairment and difficulty with use of the walker. No further interventions were identified. Review of a Nursing Progress Notes dated 12/20/24 revealed the following: -2:35 PM the resident had been taking the Clonazepam 0.5 mg twice a day and was having increased sleepiness, unsteady gait and difficulty standing. -4:13 PM the resident's physician was sent a facsimile requesting a dose reduction of the resident's Clonazepam. -11:50 PM the resident was given Haldol 5 mg IM for agitation and aggression toward staff. The resident had a very unsteady gait. Review of an Incident Report dated 12/21/24 at 1:00 PM revealed the resident's motion alarm was sounding and the resident was found on the floor of the resident's room. The staff had a difficult time with getting the resident up as the resident was unstable and lethargic. There was no evidence causal factors were assessed; current interventions were reviewed or a new intervention developed to prevent further falls. Review of a Nursing Progress Note dated 12/22/24 at 5:35 PM revealed the resident's family had expressed concerns about the resident being over medicated. Review of an Incident Report dated 12/22/24 at 8:23 PM revealed the resident motion alarm was sounding. The resident was found on the floor of the resident's room. No causal factors were identified. The staff were to ensure the resident was always wearing nonskid socks or shoes despite an intervention dated 12/9/24 to ensure the resident was wearing appropriate footwear. No further interventions were identified. Review of a telephone/verbal order sheet dated 12/24/24 revealed a new order to reduce the resident's Clonazepam order to 0.25 mg twice a day. Review of Nursing Progress Notes revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-12/25/24 at 9:55 AM the resident was drowsy with an unsteady gait and required assistance with use of the walker. -12/26/24 at 1:32 PM the resident was leaning against the wall and had difficulty with picking up feet to walk. -12/27/24 at 10:42 AM the resident's family called again to discuss concerns of the resident being overmedicated. Review of an Incident Report dated 12/27/24 at 11:30 AM revealed the resident was found on the floor by the recliner in the resident's room. Review of the resident's electronic medical record revealed no evidence causal factors were identified, current interventions revised, or new interventions developed. Review of an Incident Report dated 12/30/24 at 3:00 AM revealed the staff heard the resident's motion alarm sounding and the resident was found lying on the floor with a large amount of blood on the resident and on the floor. A laceration was observed to the resident's nose and left eye and a large bump to the back of the right side of the resident's head. The resident was unable to bear weight. The resident was sent to the emergency room (ER) for evaluation. During an interview with the Director of Nursing (DON) on 1/23/25 at 2:00 PM the DON confirmed the following regarding the resident's falls: -staff were to assess residents after each fall, determine causal factors and either revise current interventions or develop new interventions. -12/11/24 fall in the resident's room with a new intervention for a sensor alarm. -12/13/24 was started on Seroquel 50 mg twice a day and Trazadone 50 mg at bedtime for agitation, restlessness, and insomnia. A camera was placed in the resident's room with a monitor at the Nurse's station so staff could monitor the resident in their room. -12/14/24 started on Haldol 0.5 mg IM to be given every 30 minutes as needed due to behaviors. -12/16/24 started on Clonazepam 0.5 mg twice a day for behaviors and agitation and a motion alarm was placed in the resident's room. -12/18/24 the staff heard the resident fall. No causal factors were identified, current fall interventions were not revised, and no new interventions were developed. -12/19/24 the staff removed the sensor alarm from the resident's bed as the noised caused the resident to have increased agitation. -12/19/24 at 8:40 PM the resident was found on the floor of the resident's room. The staff re-educated the resident on the need to use the walker. The resident had severe cognitive deficit so uncertain if this was an effective intervention. No other interventions were indicated. -12/20/24 at 4:13 PM the physician was notified of the resident's unsteadiness, sleepiness, and recent falls with a request for a dose reduction of the resident's Clonazepam 0.5 mg twice a day. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-12/21/25 at 1:00 PM the resident was found on the floor of the resident's room. The resident was unstable and lethargic. There was no revision of fall interventions, and no new interventions were developed. -12/22/24 at 8:23 PM the resident was again found on the floor of the resident's room. Staff were to ensure the resident was wearing nonskid socks or shoes (an intervention dated 12/9/24 was already in place to ensure the resident was wearing appropriate footwear). No new interventions were indicated. -12/24/24 (4 days after the facility staff requested) the facility received a new order to reduce the resident's Clonazepam to 0.25 mg twice a day. -12/27/24 at 11:30 AM the resident was found on the floor of the resident's room. There were no causal factors and no changes in fall interventions identified. -12/30/24 at 3:00 AM the resident's motion alarm was sounding, and the resident was found on the floor. The resident had a laceration to the resident's nose and left eye with a large bump to the back of the resident's head. The resident was unable to bear weight and was sent to the hospital. -the resident passed away in the hospital on 1/3/25 due to brain hemorrhage.