

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285087	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/04/2025
NAME OF PROVIDER OR SUPPLIER Tiffany Square		STREET ADDRESS, CITY, STATE, ZIP CODE 3119 West Faidley Avenue Grand Island, NE 68803	

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 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)Based on Record review and interviews, the facility failed to ensure approved diagnosis and monitoring for medications and side effects of antipsychotic medications for 2 of 5 residents reviewed (Resident 57 and Resident 10) as required. This had the potential for adverse side effects of antipsychotic medication to go unaddressed. The facility census was 77. Findings were:A.</p> <p>Record review of the admission MDS dated [DATE] for Resident 57 revealed the resident was admitted on [DATE]. Resident 57 had no moods or behaviors, did not wander, did have frequent pain which at times interfered with daily activities, and took the following types of medications: antipsychotic, antianxiety, antidepressant, hypnotic, diuretic, and opioids.</p> <p>Record review of the Medical Diagnoses listed in the electronic medical record on 12/2/2025 revealed Resident 57 had diagnoses for depression, insomnia (difficulty sleeping), anxiety disorder, chronic pain, hypertension (high blood pressure), fractured right rib, and others.</p> <p>A record review of the working care plan (a document that describes different areas of care needed for this resident) revealed that Resident 57 was receiving medications for anxiety and depression and that staff members were to monitor for adverse effects by monitoring, documenting, and reporting specific signs and symptoms which included changes in behaviors, lack of energy, slurred speech, disorientation, depression, dizziness, light-headedness, impaired thinking or judgment, memory loss, forgetfulness, suicidal thoughts, decline in activities of daily living, constipation, tremors, insomnia, among many others.</p> <p>Record review of the Physician orders revealed Resident 57 had orders for the following psychoactive medications;</p> <p>Melatonin 3 mg every 24 hours as needed for insomnia.</p> <p>Lexapro 20 mg daily for depression</p> <p>Ambien 5 mg as needed for insomnia</p> <p>Xanax 0.25 mg every 6 hours as needed for anxiety</p> <p>Seroquel 50 mg daily at bedtime for depression</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
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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the policy dated 5/2025 Psychoactive Medication and Medication Regimen Review Management Standard revealed on page one that 1.) each Psychoactive Medication must have an appropriate diagnosis to support the use of the medication. 2.) a gradual dose reduction was required for all Psychoactive Medications. 3.) the interdisciplinary team acts as a resident advocate to ensure that psychoactive medications are necessary to ensure quality of life for each resident. 4.) there were various forms of tools for each resident which included behavior/intervention monthly flow records, AIMS (Abnormal Involuntary Movement Scale) and other tracking on the electronic medical charting system, 5.) if a resident was on an antipsychotic, it is best practice to monitor for possible seizure side effects due to the medications potentially lowering the threshold of seizures. 6.) if a resident is on a psychoactive medication, there should be a separate care plan in place (separate problem/need, goal, and interventions), 7.) The Care Plan is reflective of the Out of Character Response/Behavior and management.</p> <p>The policy defined a psychoactive drug as any drug that affects brain activities associate with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:</p> <p>Antipsychotics</p> <p>Antidepressants</p> <p>Antianxiety</p> <p>Sedative/Hypnotic</p> <p>The definition for the Indications for Use revealed this is the identified, documented clinical rationale for administering a medication that is based upon an assessment of the resident's condition and therapeutic goals and is consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical stands of proactive, medication references clinical studies or evidence-based review articles that are published in medical and or pharmacy journals.</p> <p>The policy further defined an Unnecessary Drug as those used</p> <p>In excessive dose (including duplicate drug therapy) or,</p> <p>For excessive duration or,</p> <p>Without adequate monitoring or,</p> <p>Without adequate indications for its use or,</p> <p>In the presence of adverse consequences which indicate the dose should be reduced or discontinued, or</p> <p>Any combination of the reasons above.</p> <p>The policy revealed the documentation requirements of Psychoactive Medications which included:</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Consent for use of the psychoactive medication</p> <p>Behavior and Intervention monthly flow record for out of character response tracking</p> <p>Care Planning</p> <p>Finally, the policy revealed the Guidelines for Psychoactive Medications</p> <p>Antipsychotic Medications</p> <p>Approved diagnosis for Antipsychotic medications in Schizophrenia, Schizo-affective disorder, Schizophreniform disorder delusional disorder, mood disorders, psychosis in the absence of dementia, medical illnesses with psychotic symptoms, Tourette's disorder, Huntington's disease, hiccups, nausea and vomiting associated with cancer or chemotherapy.</p> <p>An AIMS (Abnormal Involuntary Movement Scale - an assessment used to assess and monitor for abnormal irregular, involuntary movements most commonly in areas of the face, around the eyes, and of the mouth, including the jaw, tongue, and lips caused by antipsychotic medications) must be completed initially when medication order is revived and also if resident admitted on antipsychotic, then quarterly and as needed.</p> <p>Record review of the admission Medication Regimen Review dated 09/15/2025 for Resident 57 revealed the consulting pharmacist had identified the following;</p> <p>Resident 57 was receiving psychoactive medications and wanted the facility to ensure that there was an appropriate diagnosis, ongoing monitoring for efficacy, target behaviors identified, and side effect monitoring ordered per the facility policy for the Alprazolam (XANAX) used for anxiety, escitalopram (Lexapro) used for depression, quetiapine (Seroquel) an antipsychotic being used to treat depression, and zolpidiem (Ambien) being used for insomnia.</p> <p>Resident 57 was receiving PRN (as needed only) psychoactive medications and needed an appropriate stop date and to be certain there was a documented rationale and specified duration of use if to be used greater than 14 days for the alprazolam and the zolpidiem.</p> <p>Resident 57 was receiving an antipsychotic and needed to have an AIMS score completed per the facility policy and to monitor for tardive dyskinesia (a neurological condition causing involuntary, repetitive body movements, often in the face (grimacing, tongue thrusting, lip-smacking), neck, limbs, or trunk, resulting from long-term use of certain medications, particularly antipsychotics), and other extrapyramidal symptoms (movement disorders, often severe side effects of antipsychotic drugs).</p> <p>Record review of the AIMS score for Resident 57 revealed there was no AIMS score conducted upon admission [DATE] or through the current time period (12/04/2025).</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the Informed Consent for psychoactive medications was signed by Resident 57 on 09/15/2025 for the Seroquel, Lexapro, and Xanax, although under the heading Statement of Consent where an X indicated consent of the medication, no medication was listed and the forms were incomplete. Seroquel was listed as an antipsychotic to be used for the treatment of depression, Lexapro was an antidepressant to be used for the treatment of depression, and Xanax was an antianxiety medication to be used for the treatment of anxiety.</p> <p>A record review of the order dated 10/28/2025 for the Ambien (a medication for the treatment of insomnia) which was used on an as needed basis, did not have a rationale as to why it was being continued for the next 6 months from the physician. This order further revealed that the consultant pharmacist who had requested rationale for the medication had also listed the Centers for Medicare and Medicaid Systems (CMS) regulations for PRN (as needed) psychotropic use greater than 14 days, and stated that the provider must document a clinical rationale in the medical record for the continuance of the PRN agent, and indicate the duration that the medication should be continued. If continued use is greater than 14 days of this PRN order is warranted, please provide a clinical rationale as well as the duration below.</p> <p>A record review of the order dated 10/28/2025 for the Xanax given as needed for anxiety did not have a rationale indicated by the physician. This order further revealed that the consultant pharmacist who had requested rationale for the medication had also listed the Centers for Medicare and Medicaid Systems (CMS) regulations for PRN (as needed) psychotropic use greater than 14 days, and stated that the provider must document a clinical rationale in the medical record for the continuance of the PRN agent, and indicate the duration that the medication should be continued. If continued use is greater than 14 days of this PRN order is warranted, please provide a clinical rationale as well as the duration below.</p> <p>Record review of the medication administration record (MAR) for the month of 09/2025 revealed that there was no documentation related to the behaviors and other information that was to be documented about the psychoactive medications.</p> <p>Record review of the (MAR) for the month of 10/2025 revealed that there was no documentation related to the behaviors and other information that was to be documented about the psychoactive medications.</p> <p>Record review of (MAR) for the month of 11/2025 revealed that there was no documentation related to the behaviors and other information that was to be documented about the psychoactive medications.</p> <p>Record review of (MAR) for the month of 12/2025 revealed that there was no documentation related to the behaviors and other information that was to be documented about the psychoactive medications.</p> <p>Record review of the Progress Notes from the date of admission [DATE] until the current date of 12/03/2025 revealed there were no entries related to the monitoring of behaviors or side effects of the psychotropic medications.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview with the Director of Nurses (DON) on 12/04/2025 at 9:05 AM it was revealed that there should be behavior charting being completed for all residents on psychotropic medications. The DON confirmed that these medications should be closely monitored for behaviors and side effects. The DON revealed there are issues with a few of the physicians' writing rationales for the medications that they have prescribed for the residents. The DON confirmed that not all medications have a rationale even after the pharmacists have requested on. The nurses also try to reach out to these same physicians to receive a rationale for the medications, but it isn't easy to get this information at times. The DON did confirm that depression is not an acceptable diagnosis for the use of the medication Seroquel for Resident 57.</p> <p>In an interview with the Administrator on 12/04/2025 at 9:10 AM it was confirmed that the current Medical Director did not always reach out to the other physicians who have residents in the facility and ensure that the regulations for certain medications and the documentation for certain medications were being followed.</p> <p>In an interview on 12/04/2025 at 10:35 AM Confirmation from the DON that there is no behavioral charting related to the medication Seroquel for Resident 57.</p> <p>In an interview on 12/04/2025 at 11:05 AM with the Minimum Data Set Coordinator (MDS) (The MDS is used to evaluate a resident's clinical, functional, and psychosocial status, and the data collected is crucial for developing individualized care plans, monitoring resident progress, and determining facility reimbursement) confirmed that there is no AIMS Assessment in the chart for Resident 57.</p> <p>B.</p> <p>Record review of the facility policy titled Psychoactive Medication and Medication Regimen Review Management Standard dated 5/2025 revealed that an Abnormal Involuntary Movement Assessment (AIMS) (an assessment used to assess and monitor for abnormal irregular, involuntary movements most commonly in areas of the face, around the eyes, and of the mouth, including the jaw, tongue, and lips caused by antipsychotic medications) (antipsychotics are a class of medications used to treat symptoms of psychosis, such as hallucinations and delusions, which are often associated with conditions like schizophrenia, bipolar disorder, and severe depression) must be completed initially when an antipsychotic medication order is received, when a resident is admitted on an antipsychotic, and then quarterly and as needed.</p> <p>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 9/30/25 revealed that Resident 10 admitted into the facility on 2/12/24. The MDS revealed that Resident 10 takes an antipsychotic medication.</p> <p>Record review of the Order Recap Report dated 12/3/25 for Resident 10 revealed an order for Rexulti 0.5 milligrams (mg) (an antipsychotic medication) 1 tablet at bedtime dated 6/28/24. The order for Rexulti was renewed on 7/23/25.</p> <p>Record review of the current medication administration record (MAR) (a legal record of the medications administered to a resident at a facility by a health care professional) for Resident 10 for December 2025 dated 12/3/25 revealed that Rexulti 0.5 mg was administered daily to Resident 10.</p> <p>(continued on next page)</p>		

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<p>F 0605</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of the care plan dated 12/1/25 for Resident 10 revealed that Resident 10's medications included medications with a Black Box Warning (a medication with the Food and Drug Administration's strictest warnings for medications with serious risks like death or permanent injury and severe adverse effects, requiring careful resident monitoring). The care plan revealed that the consulting pharmacist will conduct monthly medication review and advise the facility related to Black Box Warning Medications. Observe the resident for any complications related to Black Box Warnings.</p> <p>Record review of the medical record for Resident 10 revealed documentation of the completion of only one AIMS assessment for Resident 10 dated 12/4/21(during a prior stay in the facility). The medical record revealed that no AIMS assessments for Resident 10 were completed during the current stay in the facility that began on 2/12/24, and no AIMS assessments were completed quarterly as required.</p> <p>Interview on 12/4/25 at 10:29 AM with the facility Director of Nursing (DON) confirmed that the DON had only found 1 AIMS assessment for Resident 10 that was from some time ago.</p> <p>Record review of the Consultant Pharmacist's Medication Review dated 10/8/25 revealed the recommendation to the facility to update the chart for Resident 10 with a more recent AIMS assessment due to Rexulti use (last AIMS in December 2021).</p> <p>Interview on 12/4/25 at 10:47 AM with the DON confirmed that Resident 10 takes the antipsychotic medication Rexulti and that AIMS assessments should be completed quarterly. The DON confirmed that the facility had not completed AIMS assessments on Resident 10 as required. The DON confirmed that the facility had not followed up on the Consultant Pharmacist recommendation.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(iv)(5)Based on record review, interview, and observation the facility failed to re-evaluate and revise interventions to treat ongoing constipation for 4 of (Residents 57, 14, 30, and 75) residents sampled. The facility census was 77.Findings were:Record review of the facility Bowel Elimination Protocol dated 06/2024 revealed that each night after midnight the night nurse will review the elimination records for their nurses' station and then prepare a list of residents who are in need of interventions for bowel management and document on the protocol sheet that is used each night.On the 2nd day or 48 hours without a Bowel Movement (BM) the staff would offer 4 ounces of prune juice or natural laxative of resident's choice and then record on the protocol worksheet.On the 3rd day (Day Shift) without a BM, the resident was to receive Milk of Magnesia (MOM) 30 ml orally or Miralax or whatever as needed medication is ordered by their physician in the morning of the 3rd day on the 6:00 AM to 2:00 PM shift. Nursing staff would also assess bowel sounds, then palpate and document assessment of results. The staff would document on the medication administration document (MAR), record the intervention on the protocol sheet, and communicate interventions and results to the oncoming shift for further actions if no BM.On the 3rd day (Evening/Night Shift) without a BM, the evening or night shift nurse would assess bowel sounds, palpate and document results before suppository administration. If no bowel sounds for the day, call the physician immediately. Then give a Dulcolax suppository as ordered a time agreeable to the resident. Document on the MAR. Communicate interventions/results to oncoming shift for further action if no BM. Record on the Protocol sheet.On the 4th day all shifts without a BM, if interventions have not been successful, contact the physician. Advance to the enema as ordered and continue with bowel assessments each shift until resolved. A.Record review of the admission Minimum Data Set (MDS) (a federally mandated, standardized assessment tool for residents in Medicare/Medicaid-certified nursing homes, used to create individual care plans, determine reimbursement (Medicare PDPM, Medicaid case mix), track quality measures, and ensure compliance during surveys, capturing comprehensive data on residents' functional, clinical, and psychosocial health for consistent and high-quality care) dated 09/18/2025 for Resident 57 revealed this resident was admitted on [DATE] with diagnoses of fractured right rib, chronic pain, depression, anxiety, osteoporosis, gastroesophageal reflux disease, and malnutrition. Resident 57 uses a wheelchair and a walker, has pain that interferes with daily activities, and needs minimal assistance with walking.Record review of the working care plan (a personalized, formal, comprehensive document that guides staff in meeting a resident's unique medical, personal, and social needs, outlining goals, treatments, preferences (like food/activities), and required support for their overall well-being, ensuring consistent, person-centered care) dated 12/04/2025 revealed there is nothing stated or care planned about Resident 57 having issues with constipation. The care plan only states: *Toilet Use: Modified independent with front wheeled walker (FWW) and intermittent supervision in room.Record review of the Bowel Assessment Form dated 09/22/2025 revealed that Resident 57 was at risk of constipation related to the use of antipsychotic medication, antidepressant medication, and opioid medications. Currently Resident 57 was continent of bowel and able to feel bodily urges to have a BM.Record review of the physician medication orders as of 12/03/2025 revealed Resident 57 was taking the following medications:Miralax 17 grams(gm) orally twice daily for constipationColace 100 milligrams (mg) one capsule orally every 12 hours as needed for constipationDulcolax Rectal suppository 10 mg one every 24 hours rectally as needed for constipationMilk of Magnesia (MOM) 30 milliliters (ml) orally every 24 hours for constipationOxycodone 10 mg orally every 6 hours as needed for pain (PRN) for a maximum of 40 mg oxycodone daily.Oxycodone 10 mg twice daily scheduled for chronic pain.Omeprazole 20 mg orally daily for gastroesophageal reflux diseaseTums 500 mg orally as needed for indigestion related to osteoporosisMagnesium Citrate (magnesium supplement and laxative) oral tablet give 1 tablet by mouth one time a day for leg cramps. There was no dosage on the medication.Acetaminophen 325 mg 2 tablets every 4 hours as needed for mild pain and fever not to exceed 3.25 grams daily.Melatonin 3 mg every 24 hours as needed for difficulty sleeping related to insomniaLexapro (escitalopram) 20 mg once daily related to depressionOndansetron disintegrating tablet 4 mg every 6 hours as needed for nausea and vomiting.Aldactone 100 mg 1 tablet daily for localized edemaLasix 20 mg one tablet daily for localized edemaAmbien 5 mg one tablet as needed for difficulty sleeping related to insomniaXanax 0.25 mg one tablet every 6 hours as needed for anxietySerenoquel 50 mg one tablet orally at</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Licensure Reference Number 175 NAC 1-005.06(D)Licensure Reference Number 175 NAC 12-006.18(B)Based on observation, record review, and interview the facility failed to perform hand hygiene (hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel) prior to applying gloves for patient contact, and failed to maintain infection control for catheter use for Resident 42. The facility census was 77. Findings are: A.</p> <p>Record review of the facility policy titled Hand Hygiene dated 9/12/17 revealed that hand hygiene is to occur before and after patient contact.</p> <p>Record review of the current care plan for Resident 7 dated 12/1/25 revealed that Resident 7 was at risk for infection related to indwelling Foley Catheter (a flexible plastic hollow tube inserted into the bladder to continuously drain urine). Interventions included proper hand hygiene.</p> <p>Observation on 12/3/25 at 2:15 PM outside the room of Resident 7 revealed that Nurse Aide-I (NA-I) put on a gown and gloves. (NA-I did not perform hand hygiene prior to putting on the gown or gloves). NA-I knocked on the room door and entered the resident room. NA-I went into the bathroom and obtained a paper towel, graduate container (a container with markings on the side that is used to measure the amount of liquids), and alcohol prep pads. Resident 7 was seated in the motorized wheelchair in the middle of the room. NA-I went to the resident. NA-I removed the catheter urine collection bag from the privacy cover. NA-I removed the drain from the holder and wiped the tip with an alcohol prep pad. NA-I opened the drain and emptied the moderate dark yellow urine into the graduate. NA-I closed the drain and wiped the tip with a new alcohol prep pad. NA-I placed the drain back into the holder. NA carried the graduate into the bathroom and observed 525cc of urine were drained. NA-I emptied the urine into the toilet and rinsed and dried the graduate.</p> <p>Interview on 12/3/25 at 2:19 PM with NA-I confirmed that hand hygiene is to be completed prior to putting on gown and gloves.</p> <p>B.</p> <p>Observation on 12/4/25 7:31 AM in the room of Resident 19 revealed that Registered Nurse-J (RN-J) administered oral medications to Resident 19. RN-J put on gloves and used the lancet (a small surgical blade with a sharp point) to poke the right middle finger of Resident 19. (RN-J did not perform hand hygiene prior to putting on gloves). RN-J wiped the first drop of blood with a cotton ball and then applied the second drop of blood to the test strip. A blood sugar reading of 98 was obtained. RN-J removed the gloves and repositioned a pillow that fell on the floor underneath Resident 19's legs. RN-J exited the room and performed hand hygiene.</p> <p>Interview with RN-J confirmed that staff were trained on performing hand hygiene and glove use to perform hand hygiene prior to putting on gloves.</p> <p>C.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of a Face Sheet dated 12/02/24 for Resident 42 revealed an admission date of 03/20/25. Additional reviews revealed a diagnosis of Neuromuscular Dysfunction of Bladder (a disorder or problem with the nerve control of urinary continence or the ability to completely void).</p> <p>A record review of a Care Plan (a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) dated 3/20/25 for Resident 42 revealed a potential risk for infection related to indwelling Foley Catheter (an invasive/aseptic device to collect urine).</p> <p>On 12/01/25 at 3:32 PM, Resident 42 was observed in their room, sitting in a recliner adjacent to their bed. Resident 42 was observed to have a tube running down the inside pant leg extended out to a urine collection bag (catheter) hanging onto the trash can between the recliner and the bed. The can was observed to have various items of trash inside of the can.</p> <p>On 12/02/25 at 10:13 AM, Resident 42 was observed in their room, sitting in the recliner. The catheter was observed to be hanging onto the trash can. The trash can had various items in the trash can.</p> <p>On 12/02/25 at 4:04 PM, Resident 42 was observed in their room, sitting in the recliner. The catheter was observed to be sitting on the floor next to the trash can.</p> <p>On 12/03/25 at 10:11 AM, Resident 42 was observed in their room, sitting in the recliner while medications were dispensed to Resident 42 by the Medication Aide. The catheter was observed to be hanging onto the trash can.</p> <p>On 12/04/25 at 10:25 AM, Resident 42 was observed in their room, sitting in the recliner. The catheter was observed to be hanging onto the trash can. The trash can had various items in the trash can.</p> <p>An interview with the Infection Control and Prevention Nurse (IP) on 12/04/25 at 10:35 AM revealed knowledge that staff were hanging the catheter bags on trash cans. The IP Nurse further revealed and agreed that this is an infection control risk for residents with indwelling foley catheters.</p>		