

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285088	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Accura Healthcare of Hartington		STREET ADDRESS, CITY, STATE, ZIP CODE 401 W Darlene Street Hartington, NE 68739	

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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Licensure Reference Number 175 NAC 12-006.09(H)(vi)</p> <p>Based on record review and interview; the facility failed to ensure that Resident 5 was free from use of unnecessary medications as a psychotropic medication (medication that affects the mind, emotions, and behavior) had been initiated without an indication for use. The sample size was 5 and the facility census was 32.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of the facility policy Use of Psychotropic Drugs with a review date of 2/2020 revealed the following:</p> <p>-Residents were not given psychotropic drugs unless the medication was necessary to treat a specific condition, as diagnosed and documented in the medical record, -the indication for initiating psychotropic medication's would be determined by the resident's actions and behaviors, -the indications for the use of psychotropic medications would be documented in the medical record, and</p> <p>-psychotropic medications would be initiated after admission after medical and physical causes had been identified and addressed.</p> <p>B.</p> <p>A record review of Nursing Progress Notes for Resident 5 revealed the following:</p> <p>-On 12/12/24 the resident was admitted from the assisted living facility and admitted with a psychotropic medication and an antidepressant. The resident's mood was pleasant, and no behaviors were witnessed.</p> <p>-On 12/14/24 at 11:52 PM nursing progress notes revealed that the resident's mood was pleasant with no behaviors.</p> <p>-On 12/18/24 a Social Services note revealed that the resident had confusion at times with a diagnosis of neurocognitive disorder with Lewy bodies (neurocognitive disorder that caused a gradual decline in mental abilities).</p> <p>-On 12/23/24 the psychotropic medication was discontinued.</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 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-From 12/24/24 to 1/7/25 nursing progress notes revealed that no behaviors had been documented.</p> <p>-On 1/7/25 a behavior meeting occurred with no change in medications.</p> <p>-From 1/7/25 to 1/27/25 nursing progress notes revealed that no behaviors had been documented.</p> <p>-On 1/27/25 the resident went to a neurology appointment with family and returned with an order for Seroquel (psychotropic medication) 12.5 milligrams (mg) at bedtime for 2 weeks then increase to 25mg at bedtime for diagnosis of Neurocognitive Disorder with Lewy Bodies.</p> <p>-On 1/31/25 at 10:20 AM nursing progress note revealed that staff had noted an increase in sleepiness in the morning, was difficult to awaken, and the neurologist had been notified.</p> <p>-On 1/31/25 at 1:19 PM nursing progress note revealed that the resident was showing more signs of confusion and wandering.</p> <p>A record review of Resident 5's Physician Visit/Communication Record dated 1/27/25 revealed Resident 5 went to a neurology appointment for a check-up. The Progress Notes section revealed Want to add Seroquel back. Start 12.5mg at bedtime x2 weeks, then increase to 25mg at bedtime. Do not remove unless directed by Neurology Clinic. This will be alongside to Celexa. The document did not include any evidence of an indication for the medication to be given to the resident.</p> <p>An interview on 1/29/25 at 9:45 AM with the Director of Nursing (DON) verified that the resident was admitted from an assisted living facility with a psychotropic medication, the resident did not have any documented behaviors and the psychotropic medication was stopped on 12/23/24. Further interview confirmed the psychotropic medication was restarted on 1/27/25 after a neurology appointment, the neurologist documented the medication could only be stopped by the neurology clinic and the resident was not exhibiting behaviors. The DON confirmed that the facility did not address stopping the psychotropic medication after 1/27/25 when the Resident 5 was not having behaviors or meeting the requirement for the medication prescribed.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Licensure Reference Number 175 NAC 12.006.12(D)(vi)</p> <p>Based on observation, record review, and interview; the facility failed to ensure insulin pens were dated when opened for Residents 25 and 26. The sample size was 2 and the facility census was 32.</p> <p>Findings are:</p> <p>A record review of the undated facility policy Administering Medications revealed the following:</p> <ul style="list-style-type: none"> -medications are administered in a safe and timely manner, and -when opening a multi-dose container, the date opened is recorded on the container. <p>A.</p> <p>A record review of Resident 26's January 2025 medication administration record (MAR) revealed an order for Tresiba (a long-acting insulin) 6 units to be given 2 times daily.</p> <p>An observation on 1/30/25 at 7:30 AM with Registered Nurse (RN)-F revealed RN-F obtained Resident 26's Tresiba insulin pen out of the medication cart for administration. The Tresiba insulin pen had been opened and did not have an open date documented on it.</p> <p>B.</p> <p>A record review of Resident 25's January 2025 MAR revealed an order for Lantus (a long-acting insulin) 23 units to be given at bedtime.</p> <p>An observation of the medication cart on 1/30/25 at 7:35 AM revealed Resident 25's Lantus insulin pen had been opened and did not have an open date documented on it.</p> <p>An interview on 1/30/25 at 7:35 AM with RN-F confirmed that Resident 26's Tresiba pen and Resident 25's Lantus pen had been opened and had not been dated, but should have been.</p> <p>An interview on 1/30/25 at 10:30 AM with the Director of Nursing confirmed that the facility's expectation was for each resident's insulin pen to be dated when opened.</p>		