

| | | | |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285104 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/06/2025 |
| NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Plattsmouth | | STREET ADDRESS, CITY, STATE, ZIP CODE 602 South 18th Street Plattsmouth, NE 68048 | |

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** B. An observation on 02/16/2025 at 1:09PM with the Maintenance Director (MD) during a facility tour revealed the following:</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] had a hole in the wall at the floorboard level of the bathroom. -room [ROOM NUMBER] the base of the toilet was stained, there was a hole at the base of the bathroom door, the caulking around the bathroom sink was visibly cracked and there was a strong urine odor. -room [ROOM NUMBER] had unpainted repairs to the wall around the window. -room [ROOM NUMBER] had a stained toilet base with a strong urine odor, scratches to the wall behind the bed nearest the door and the caulking around the heating unit was cracked. -room [ROOM NUMBER] was missing a light cover over bed nearest the window, the base of the toilet was stained, and 2 lights were out in the bathroom. -In the memory care unit, the wallpaper border above the rooms NW4, NW7, NW8 and NW9 was torn and missing in places. -The utility sink in the memory care unit had a sharp uneven hole to the right rear of the sink unit and the back board of the sink was cracked and separating from the counter. -The handrail to the exterior steps beside the south entrance was rusted and not secured to the right side of the bottom step. <p>An interview with the Maintenance Director at 1:09 PM confirmed the above issues and further confirmed there were no active work orders for any of the issues mentioned.</p> <p>Licensure Reference Number 175 NAC 12-006.19</p> <p>Based on observation, and interview the facility failed to ensure that a doorbell was functional at the north entrance of the facility, this had the potential to affect 32 residents identified as independent with mobility from a facility census of 82. The facility failed to ensure wallpaper, walls, light covers, and fixtures were maintained in clean condition and good repair, in 9 (302, 303, 306, 405, 408, NW4, NW7, NW8, and NW9) of 43 occupied resident rooms. The facility failed to maintain a utility sink in good repair in the memory care unit. This had the potential to affect 15 of 16</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 |
|---|-------|-----------|

| | | | |
|--|---|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285104 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/06/2025 |
| NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Plattsmouth | | STREET ADDRESS, CITY, STATE, ZIP CODE 602 South 18th Street Plattsmouth, NE 68048 | |
| 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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>residents that reside on the unit. The facility to ensure an exterior stair hand railing was secured to the bottom step at the entrance to the south side of the facility. This had the potential to affect 12 residents identified as self-mobile without assistive devices. The facility census was 82.</p> <p>The findings are:</p> <p>A. An interview conducted with Social Service Director (SSD) on 02-05-2025 at 11:52 AM revealed that residents that are outside can enter the south entrance to the facility by the push button automatic door and the main entrance and the service entrance both have doorbells for the residents to ring if they need help back in the facility.</p> <p>An observation conducted on 02-05-2025 at 1:06 PM of the front door revealed when the doorbell was pushed that no one answered the door. The temperature outside was 26 degrees Fahrenheit.</p> <p>An interview conducted on 02-05-2025 at 1:12 PM with the Receptionist (Rec) E confirmed that the doorbell at the main entrance did not sound when pushed.</p> <p>An interview conducted with the Administrator in Training (AIT) on 02-05-2025 at 1:23 PM confirmed the doorbell chime was not plugged in at the main entrance as it should have been, therefore the doorbell did not sound.</p> | | |

| | | | |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285104 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/06/2025 |
| NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Plattsmouth | | STREET ADDRESS, CITY, STATE, ZIP CODE 602 South 18th Street Plattsmouth, NE 68048 | |

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>Licensure Reference Number 175 NAC 12-006.09(l)(i)(1)</p> <p>Based on observation, interview and record review the facility failed to implement interventions to prevent falls for 1 (Resident 54) of 4 residents sampled. The facility census was 82.</p> <p>The findings are:</p> <p>Record review of Resident 54's Minimum Data Set (MDS; a federally mandated assessment tool used for care planning) dated 12-30-2024 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) was scored as a 0. According to the MDS Manual a score of 0-7 indicates severe cognitive impairment. -required extensive assistance with toileting and showering -required moderate assistance with dressing, transfers, and bed mobility <p>Record review of Resident 54's Comprehensive Care Plan revealed Resident 54 was at risk for falls and the interventions dated 01-06-2025 to prevent falls for Resident 54 was Dycem (a non-slip product that grips on both sides to prevent sliding) to the wheelchair seat.</p> <p>An observation on 02-05-2025 at 7:36 AM revealed no Dycem in Resident 54's wheelchair.</p> <p>An observation on 02-05-2025 at 9:30 AM revealed no Dycem in Resident 54's wheelchair.</p> <p>An interview with Nursing Assistant (NA) I on 02-05-2025 at 9:40 AM revealed fall interventions for Resident 54 were for gripper socks, non-skid strips next to the bed and to wear shoes when transferring. NA I reported Resident 54 doesn't need anything applied to the wheelchair because Resident 54 does well in the wheelchair.</p> <p>An observation on 02-06-2025 at 12:22 PM of Resident 54's wheelchair with the Director of Nursing (DON) revealed no Dycem on the seat of the wheelchair. An interview conducted with the DON immediately following the observation confirming the intervention of Dycem in the wheelchair was not implemented according to the care plan.</p> <p>Record review of the facility policy Fall Prevention revealed the following:</p> <ul style="list-style-type: none"> -Policy statement: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -provide additional interventions as directed by the resident's assessment including but not limited to assistive devices, increased frequency of rounds, low bed, alternative call system access and therapy referrals. -each resident's risk factors and environmental hazards will be evaluated when developing the <p>(continued on next page)</p> |

| | | | |
|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285104 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/06/2025 |
| NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Plattsmouth | | STREET ADDRESS, CITY, STATE, ZIP CODE 602 South 18th Street Plattsmouth, NE 68048 | |

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 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>comprehensive plan of care. Interventions will be monitored for effectiveness, and the plan of care will be revised as needed.</p> |

| | | | |
|--|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285104 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/06/2025 |
| NAME OF PROVIDER OR SUPPLIER Prestige Care Center of Plattsmouth | | STREET ADDRESS, CITY, STATE, ZIP CODE 602 South 18th Street Plattsmouth, NE 68048 | |
| 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 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure medication error rates are not 5 percent or greater.</p> <p>Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on observation, interview and record review the facility failed to ensure a medication error rate of 5% or less as evidenced by 2 errors out of 28 opportunities for error resulting in a medication error rate of 7.14%. This affected 1 (Resident 328) of 3 residents sampled. The facility census was 82.</p> <p>The Findings are:</p> <p>An observation on 02-05-2025 at 9:50 AM of Medication Aid (MA) J administering medications for Resident 328 revealed MA J administered the following:</p> <ul style="list-style-type: none"> -levothyroxine 75 micrograms (mcg) administered 1 tablet -Tylenol 500 milligrams (mg) tablet administered 2 tablets -lansoprazole 3mg per 1 milliliter (ml) administered 10 ml. <p>An interview was conducted with MA J during the observation on 02-05-2025 at 9:50 AM revealed Resident 328 had already ate breakfast.</p> <p>Record Review of Resident 328's physician orders dated 1-25-2025 revealed the following:</p> <ul style="list-style-type: none"> -levothyroxine 75 micrograms (mcg) tablet give 1 tablet on an empty stomach. Give 30 minutes prior to the meal. -Tylenol 500 milligrams (mg) tablets give 2 tablets three times a day. -lansoprazole 3mg per 1 milliliter (ml) give 10 ml by mouth with breakfast. <p>An interview with MA J on 02-06-2025 at 6:48 AM confirmed levothyroxine should have bee given 30 minutes prior to breakfast and lansoprazole should have been given with breakfast.</p> <p>Record review of the facility policy Medication Administration dated 01-2025 revealed the following:</p> <ul style="list-style-type: none"> -Policy statement: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. - compare medication with the medication administration record to verify the resident's name, medication name, form, dose, route, and time. -administer medication as ordered in accordance with manufacturer's specifications. | | |