STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285220	A. Building B. Wing	05/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wauneta Care and Therapy Center	427 Legion Street Wauneta, NE 69045

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.08(A) Based on record reviews and interviews, the facility failed to ensure that all residents who were admitted to the facility had a written recommendation or had written orders from a physician. This affected 1 (Resident 32) of 12 residents sampled. The facility census was 30. Findings are: Record review of the admission orders for Resident 32 who was admitted to the facility on [DATE], revealed the orders had been written and signed on 12/18/2024 at 8:27 AM by Physician Assistant (PA)-H (a licensed healthcare professional who works with physicians to provide medical care - a non physician care provider). There was no co-signature of a physician (An MD or Medical Doctor) on these orders. According to the admission orders the resident had diagnoses for status post left hip replacement with complications, chronic right hip hardware infection, long term use of suppressive antibiotic use, hypertension, allergic rhinitis, history of deep vein thrombosis (blood lots), history of arterial embolism, anticoagulation (use of blood thinners to reduce the chances of blood clotting), left foot drop, muscle weakness, anxiety, and over active bladder. The resident was to see Physical Therapy and Occupational Therapy. Interview on 5/12/2025 at 3:05 PM with the Director of Nursing (DON) revealed that Resident 32's primary care provider was PA-H. DON confirmed the admission orders were signed by a physician assistant and not a physician. When asked about a physician caring for the resident, DON stated again that the primary care provider was PA-H. DON then stated that PA-H is a Physician Assistant and that Resident 32 was not followed by a physician, just the physician assistant. Interview on 5/13/2025 at 2:30 PM with DON who confirmed that after going through Resident 32's medical records, there was no information from a physician that recommended nursing home placement and a physician did not sign the admission orders.

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: 285220	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2025
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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** E. Record review of the admission Record dated 5/8/25 for Resident 10 revealed that Resident 10 was admitted into the facility on [DATE]. Diagnoses included fracture of the lower spine, rectal cancer, and nutritional deficiency. Record review of the Emergency Department Provider Note dated 10/11/24 for Resident 10 revealed that the emergency physician (a Medical Doctor/MD) recommended admission to the facility for nursing home care. Record review of the Progress Note dated 10/23/24 at 4:02 PM for Resident 10 revealed that Advanced Practice Registered Nurse-F (APRN-F) (a registered nurse with advanced education and certification in a specific area of nursing practice. A non-physician care provider.) was in the facility for the 30-day nursing home recertification for Resident 10. (The 30-day visit was performed by a non-physician care provider). Record review of the History and Physical dated 11/1/24 for Resident 10 revealed that Resident 10 was evaluated by APRN-F. Record review of the Progress Note dated 1/2/25 at 1:01 PM for Resident 10 revealed that APRN-F was in the facility for the 60-day nursing home recertification for Resident 10. (The 60-day visit was performed by a non-physician care provider). Record review of the resident's profile page in the electronic health record for Resident 10 dated 5/12/25 revealed that APRN-F was listed as the resident's physician. F. Record review of the admission Record dated 5/8/25 for Resident 31 revealed that Resident 31 was admitted into the facility on [DATE]. Diagnoses included fracture of the left leg, hypokalemia (a condition where the body has too little potassium. The condition can cause life-threatening complications including heart arrhythmias), and breast cancer. Record review of the Transition Orders and Information for the Continuation of Patient Care for Resident 31 dated 11/12/24 revealed that the physician ordered resident admission to the nursing facility for care. The document revealed a follow-up appointment was scheduled for 11/19/24 with Advanced Practice Registered Nurse-G (APRN-G). Record review of the Progress Note dated 12/19/24 at 8:35 AM for Resident 31 revealed that APRN-G was in the facility for the 30-day nursing home recertification for Resident 31. (The 30-day visit was performed by a non-physician care provider). Record review of the Progress Note dated 2/21/25 at 4:56 PM for Resident 31 revealed that APRN-G was in the facility for the 60-day nursing home recertification. (The 60-day visit was performed by a non-physician care provider). Record review of the resident's profile page in the electronic health record for Resident 31 dated (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/12/25 revealed that APRN-G was listed as the resident's physician. Interview on 5/12/25 at 3:04 PM with the facility Director of Nursing (DON) confirmed that a physician is an MD and that Advanced Practice Registered Nurse-G is not a physician. Based on record reviews and interviews, the facility failed to ensure that residents were seen by a physician during the initial 30-day visit and at a minimum of every other visit. This affected 6 (Residents 10, 18, 25, 28, 31, and 32) of 12 sample residents reviewed. The facility census was 30. Findings are: Interview with the Director of Nursing (DON) on 05/08/2025 at 1:35 PM revealed that the DON believed that a physician assistant or nurse practitioner could perform all the 60-day certifications for nursing home residents after admission. At that time when asked about specific residents, the DON showed examples on the computer of the primary care physician for 2 residents was a Physician Assistant listed on the resident profile status. Another resident example revealed one resident's primary care physician was an Advanced Practice Registered Nurse. DON confirmed that the words primary care physician and primary care practitioner were used interchangeably but that they are not the same. DON confirmed a nurse practitioner and a physician assistant are not physicians. A. Record review of the Physician's Progress Notes for Resident 18 revealed that the Physician's Assistant (PA)-H (a licensed healthcare professional who works with physicians to provide medical care. An advanced practice non physician medical provider) had written notes during the 60 day on site recertification visits on the following dates: -06/11/2024 -08/20/2024 -10/15/2024 -12/23/2024 -02/03/2025 -02/28/2025 -04/15/2025 Record review of the office and clinic notes written on 06/11/2024 revealed Resident 18 was seen by PA-H for a 60-day recertification visit. This document revealed Resident 18 had a medical history of chronic bronchitis, chronic obstructive pulmonary disease, congestive heart disorder, diastolic heart failure, hypertension, edema, and osteoporosis. The diagnoses of chronic obstructive pulmonary disease, congestive heart failure, edema, and hypertension had been addressed during the visit. Record review of the office and clinic notes written on 10/15/2024 revealed Resident 18 was seen by PA-H for a 60-day recertification visit. The diagnoses of chronic obstructive pulmonary disease, (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	congestive heart failure, hypertension, and osteoporosis had been addressed during the visit. Record review of the hospital discharge instructions dated 10/30/2024 for Resident 18 revealed the resident was seen by PA-H at the hospital. The diagnoses of chronic obstructive pulmonary disease, congestive heart failure, hypertension, and osteoporosis had been addressed during the visit. Record review of the office and clinic notes written on 12/18/2024 revealed Resident 18 was seen by PA-H for a 60-day recertification visit. Resident 18's congestive heart failure, edema, hypertension, osteoporosis, and hypoxemia had been addressed during the visit. Record review of the office and clinic notes written on 02/18/2025 revealed Resident 18 was seen by PA-H for a 60-day recertification visit. Resident 18's Congestive heart failure, edema, urinary incontinence, and hypertension were addressed as were the resident's medications during the visit. Record review of the Office and Clinic Notes from 04/15/2025 revealed Resident 18 was seen by PA-H for a 60-day recertification visit. Resident 18's Congestive heart failure, edema, hypothyroidism, and chronic obstructive pulmonary disease were addressed as were the resident's medications during the visit. Interview on 05/12/25 at 3:05 PM with the facility Director of Nursing (DON) confirmed that Resident 18 was not seen by a doctor on every other recertification visit. B. Record review of the Medical Diagnoses document for Resident 25 revealed an admission date of 05/31/2023 and had diagnoses of Alzheimer's disease, chronic obstructive pulmonary disease, chronic kidney disease stage 3B, hypothyroidism, hyperparathyroidism, dementia with behavioral, psychotic and mood disturbances, and anxiety. Record review of Resident 25's medical records revealed no evidence the resident had been evaluated by a physician during their stay in the facility. Record review of the emergency room physician notes for Resident 25 revealed the resident was seen by PA-H on 06/23/2024 for low back pain and a fall. Interview on 05/13/25 at 1:31 PM with the DON confirmed Resident 25 had not been evaluated by a physician during their stay at the facility. C. Record review of the 01/28/2025 quarterly Minimum Data Set (MDS - a standardized assessment tool used to collect data on the health and functional status of residents used to create care plans) revealed Resident 28 was admitted to the facility on [DATE]. Resident 28 had medically complex conditions which included coronary artery disease, congestive heart failure, hypertension, renal insufficiency, diabetes, Alzheimer's disease, pressure ulcers and other skin conditions. Resident 28's drug regimen included medications for anxiety, depression, anticoagulation (to reduce blood clots), diuretics for edema, opioid pain medications, and hypoglycemics for blood sugar control. Record review of the Physician Progress Notes revealed Resident 28's records had one entry for a (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	60-day recertification on 08/15/2024, when Resident 28 was seen by advanced practice registered nurse (APRN)-G (a registered nurse with advanced education and certification in a specific area of nursing practice. A non-physician care provider.) Record review of the Office and Clinic Notes for Resident 28 revealed the resident was seen on 08/15/2024 for a 60-day recertification visit. Resident 28's anxiety, depression, chronic systolic congestive heart failure, dementia, gastroesophageal reflux disease, hyperlipidemia, hypertension, kidney failure, sacral ulcer and diabetes were addressed during the visit as were the medications. Record review of the hospital transfer notes written and faxed to the facility on [DATE] revealed the resident was seen in the hospital by physicians. The patient was in the hospital from [DATE] to 10/20/2024. The resident had been hospitalized for gallbladder removal. Record review of the Office and Clinic Notes dated 11/06/2024 revealed that Resident 28 was seen by APRN-G for a 60-day recert and addressed the following medical issues for Resident 28: osteoporosis, edema, acute chronic systolic heart failure, adjustment disorder, anxiety, atrial fibrillation, chronic pain, dementia, depression, gastroesophageal reflux, hyperlipidemia, insomnia, hypertension kidney failure, pulmonary hypertension and status post gallbladder removal as well as the medications at this visit. There were no records to review during the month of 1/2025 for Resident 28 in reference to a required recertification visit for the nursing home. Record review of the Office and Clinic Notes dated 02/21/2025 revealed that Resident 28 was seen by APRN-G for a 60-day recertification and addressed the following medical issues: Diabetes, Stage 3B kidney disease, sacral ulcer, diabetic ulcer of the left great toe, chronic pain, anemia, osteoarthritis, anxiety, adjustment disorder, depression, dementia, insomnia, pulmonary hypertension, Atrial fibrillation, and chronic systolic congestive heart failure as well as the medications at this visit. There were no records to review for recertification visits for Resident 28 during the month of March 2025. Record review of the Office and Clinic Notes dated 04/28/2025 revealed that Resident 28 was seen by APRN-G for a Medicare Nursing Home recertification, and addressed the following medical issues for Resident 28: pressure ulcer of the left leg, adjustment disorder, anxiety, atrial fibrillation, chronic pain, chronic systolic heart failure, constipation, coronary artery disease, dementia, depression , edema, gastroesophageal reflux, history of cardioversion, history of femur fracture, history of septic shock, hyperlipidemia, hypertension, insomnia, anemia, long term use of high risk medications, peripheral vascular disorder, pulmonary hypertension, diabetes, osteoarthritis, and gout secondary to renal impairment as well as the medications at this visit. Interview on 05/12/25 at 3:05 PM with the facility Director of Nursing (DON) confirmed Resident 28 had only been seen by the APRN for recertification and 60-day Nursing Home rounds. D. Record review of the Discharge summary dated [DATE] revealed Resident 32 was admitted to swing bed at the local hospital on [DATE]. Resident 32 was transferred to the local facility following a hip fracture and hip revision on 10/31/2024. Resident 32 was admitted for strengthening but physical (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	therapy progressed slowly and the agreement was made between the facility and the local hospital to transfer Resident 32. Record review quarterly MDS dated [DATE] revealed Resident 32 was admitted to the facility on [DATE] and had medically complex conditions. Resident 32 had infection due to orthopedic joint prosthesis, a methicillin susceptible staphylococcus infection, long term use of antibiotics, acute clotting in the deep veins of the lower extremities, left sided foot drop, depression, malnutrition, and a surgical wound. Resident 32 took medications for depression, a long-term antibiotic, diuretics for fluid retention, and opioids for pain. Record review of the admission orders for Resident 32 revealed this resident was admitted for left hip replacement with complications, chronic right hip hardware, long term use of suppressive antibiotics, hypertension, allergic rhinitis, history of deep vein thrombosis, history of arterial embolism, anticoagulation, left sided foot drop, muscle weakness, anxiety and over active bladder. The attending Physician Assistant signed the admission orders. Interview with the DON on 05/12/2025 at 10:45 AM who confirmed there was no recertification visit found for Resident 32 during the month of January. Review of the office visit note from 02/04/2025 when Resident 32 was seen by a physician at the clinic. This was the initial visit since being admitted to the facility from the local hospital. The initial visit (30-day recertification visit) by the physician was due on 01/17/2025 and should have been completed on or before 01/27/2025. Record review of the office visit note completed on 03/12/2025 revealed Resident 32 was seen for complaints of hip pain, questions about pain medications, physical therapy progress, no feeling in the left foot, and dry mouth. Medications were review and a treatment plan put into place by PA-H. Record review of the 60-day recertification for Medicare for Resident 32 was done on 04/15/2025 and completed by PA-H. Interview on 5/12/25 at 3:05 PM with the facility Director of Nursing (DON) confirmed that a physician did not routinely see Resident 32.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on record reviews and interviews, the facility failed to ensure gradual dose reductions were completed for residents taking psychotropic medications. This affected 1 (Resident 23) of 5 sampled residents. The facility census was 30. Findings are: Record review of the 02/11/2025 quarterly Minimum Data Set (MDS - a standardized, comprehensive assessment tool used to evaluate and document the health status of residents in Medicare and Medicaid certified nursing homes) revealed Resident 25 was unable to answer questions to perform a Brief Interview for Mental Status exam (BIMS), got annoyed eaily and was short tempered, had poor appetite, difficulty concentrating, had delusions, would verbally and physically act out towards others, rejected cares one to three days a week, wandered 4 to 6 days a week, was able to ambulate with their walker throughout the facility, and had urinary incontinence. Resident 25 was diagnosed with renal insufficiency, Alzheimer's dementia, anxiety disorder, adjustment disorder with mixed disturbances of emotions and conduct, and had orders for antipsychotics, antidepressants, and anti-anxiety medications. Record review of the physician orders revealed Resident 25 received buspirone (an anti-anxiety medication) for generalized anxiety disorder, mirtazapine (an antidepressant medication) for Alzheimer's disease, and sertraline (an antidepressant medication) for dementia with anxiety. Record review of Resident 25's medical records revealed no evidence of a gradual dose reduction being attempted for psychotropic medications for Resident 25 in the past year. There were also no orders with rationales by a physician that stated a gradual dose reduction was not to be completed. Interview on 05/13/2025 at 1:20 PM with Director of Nursing (DON) who stated Resident 25 had been seen by one mental health practitioner group and then the facility switched to a new group. DON was unable to find any GDR for Resident 25. Interview on 05/13/2025 at 3:30 PM with DON confirmed the staff had been unable to find a gradual dose reduction or any physician documentation related to a contraindication for doing a dose reduction for Resident 25.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D) Based on observations, record reviews, and interviews, the facility failed to ensure that medication error rates were less than 5%. This was based on 31 medication administration opportunities and 2 medication errors resulting in an error rate of 6.5%. This affected 2 (Residents 27 and 18) of 4 sampled residents. The facility census was 30. Findings are: Record review of the undated facility policy The Five Rights of Medication Administration stated the safe provision of medication also includes observing a rule called the Five Rights. The Five Rights consist of several safety checks which help to prevent mistakes. While providing medications, give the right drug to the right resident, at the right amount at the right time, and by the right route. The five rights of medication administration are: -right drug -right resident -right amount -right time -right route Record review of the March 2010 policy Medication Errors - Defined revealed in paragraph 4 that medication errors can be made by not following accepted practice standards of medication provision. Examples included: -Giving a drug before a meal instead of after a meal when ordered -Given at the wrong time (anytime one hour prior to or one hour after the scheduled time) -Omitted or not given -Given by the wrong route -Wrong dose -Wrong drug -Wrong resident A. Record review of the May 2025 Electronic Medication Administration Record (EMAR) for Resident 27 revealed an order for acetaminophen extra strength 500 milligrams (mg), two tablets to be given four (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times a day at 9:00 AM, 12:00 PM, 5:00 PM, and at 9:00 PM for pain management. Observation on 05/08/2025 at 7:50 AM revealed Licensed Practical Nurse (LPN)-J administering medications to Resident 27, including the two tablets of acetaminophen 500mg, which was not due until 9:00 AM. Interview with LPN-J on 05/08/2025 at 7:50 AM revealed Resident 27 prefers their acetaminophen to be administered at this time rather than at the time it was ordered for. B. Record review of the May 2025 EMAR for Resident 18 revealed an order for acetaminophen 500 mg 4 times a day, with the first dose due at 7:00 AM. Observation on 05/08/2025 at 8:10 AM of LPN-J who gave medications, including the acetaminophen 500 mg, to Resident 18 at the dining room table. Interview on 05/08/2025 at 8:13 AM with LPN-J who confirmed that the acetaminophen was administered late to Resident 18. Interview on 05/08/2025 at 8:50 AM with the Director of Nursing (DON), who revealed that medications are in the medical records system with a specific administration time, and all are due in the time period of one hour before or one hour after the scheduled time. If the medications are given outside that time, then those medications were not given at the right time and that is a medication error.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1) Based on record review and interview the facility failed to ensure that nurse aides received a minimum of 12 hours of continuing education per year as required for 1 of 5 sampled nurse aides. This had the potential to prevent residents from receiving competent care. The facility census was 30. Findings are: Record review of the facility policy titled Required Training, Certification and Continuing Education of Nurse Aides dated 3/12/24 revealed that it is the facility policy to comply with State and Federal regulations and requirements as they pertain to continuing education of nurse aides. The facility will provide at least 12 hours of in-service training annually, based on employment date and not on calendar year. Record review of the undated facility Employee List revealed that Nurse Aide (NA)-E had a hire date of 2/1/22. Record review of the facility Training Hours report dated 5/8/25 for NA-E for the date range of 2/1/24 through 2/1/25 (the annual period based on NA-E's employment date) revealed that NA-E completed a total of 2.85 hours of continuing education. Interview on 5/12/25 at 1:11 PM with the Facility Administrator (FA) confirmed that NA-E completed 2.85 hours of continuing education during the annual year based on the employment date of NA-E. The FA confirmed that NA-E did not complete 12 hours of continuing education as required.