STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabitha at Prairie Commons	3490 Ewoldt Street 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)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice-SNFABN Form CMS 10055 (a notice issued to a resident and/or responsible party to inform them that Medicare will no longer pay for their services) and Notice of Medicare Non-Coverage-NOMNC Form CMS 10123 (a notice required to be provided by the facility to beneficiaries (residents) that are receiving nursing services paid for by Medicare Part A explaining that skilled nursing services will no longer be paid for by Medicare and informing the residents of the right to appeal) for discharge from Medicare Part A to 2 (Residents 5 and 125) of 3 residents sampled which resulted in the potential to prevent Resident 5 and 125 from filing an appeal of the discharge from Medicare Part A covered services. The facility census was 23. Findings are: A. Record review of the undated SNF Beneficiary Notification Review for Resident 5 revealed this resident started Medicare Part A skilled services on 10/16/2024. The last date of coverage for part A services occurred on 01/01/2025. This was a facility/provider-initiated discharge from Medicare Part A services. Resident 5 remained in the facility after being released from Skilled Care and had a full year of days remaining. Staff indicated that the resident reached highest practical level (of recovery) at that time but continued to have 4 more weeks of weight bearing as tolerated with (Resident 5's) arm. Further review revealed SNF ABN, Form CMS-10055, was not provided to Resident 5 with an explanation that stated Resident didn't indicate further desire for therapy at the time. Interview with the Assistant Administrator (AA) on 04/28/2025 at 2:45 PM revealed that there had been a change in social services and a few things have slipped through the cracks. We are still looking for some of our documentation. Interview on 04/29/2025 at 10:12 AM confirmed the facility staff had been unable to locate anymore information pertaining to the beneficiary notice; and, confirmed a copy of the Form CMS-10055 was not found for Resident 5. B. Record review of the undated SNF Beneficiary Notification Review for Resident 125 revealed this resident started Medicare Part A skilled services on 10/17/2024. The last date of coverage for part A services occurred on 11/20/2024. This was a facility/provider-initiated discharge from Medicare Part A services and benefit days were not exhausted. Resident 125 remained in the facility after being (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Tabitha at Prairie Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 3490 Ewoldt Street Grand Island, NE 68803	

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	released from Medicare A Skilled care and had 65 days remaining of benefits. Further review revealed SNF ABN, Form CMS-10055, was not provided to Resident 125 with an explanation that stated Resident 125 was on MCA (Medicare A Services) not part B. Resident wasn't indicating desire to continue therapy. Secondly, the beneficiary review also revealed that the resident had not been given a Notice of Medicare Non-Coverage letter. The written facility explanation stated not able to locate the NOMNC. See documentation in the EMAR (electronic medical record) resident and family notification. Interview with the Assistant Administrator (AA) on 04/28/2025 at 2:45 PM revealed that there had been a change in social services and a few things have slipped through the cracks. We are still looking for some of our documentation. Interview on 04/29/2025 at 10:12 AM confirmed the facility staff had been unable to locate any more information pertaining to the beneficiary notice. AA confirmed there was a written explanation about the NOMNC in the EMAR, but Staff were unable to find the NOMNC.

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** B. Record review of the admission Record dated [DATE] for Resident 18 revealed that Resident 18 admitted into the facility on [DATE]. Diagnoses included high blood pressure, atrial fibrillation (an irregular heart rhythm that can lead to blood clots and stroke), old myocardial infarction (heart attack), hyperlipidemia (elevated levels of cholesterol and triglycerides in the blood that can cause heart attack and stroke), coronary angioplasty implant and graft (surgery to repair blocked heart arteries), and history of malignant neoplasm of the prostate (prostate cancer). The admission Record revealed Do Not Resuscitate as another diagnoses. Record review of the care plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated [DATE] for Resident 18 revealed a self-care deficit related to heart attack with damage to the heart muscle (NSTEMI). Record review of the resident profile page in the electronic health record dated [DATE] for Resident 18 revealed a code status of Full Code. Full code means that Cardiopulmonary Resuscitation (CPR) (a lifesaving attempt combination of rescue breathing and chest compressions when someone's heart has stopped/cardiac arrest) would be initiated if the resident's heart stopped. Record review of the Advanced Directives form dated [DATE] for Resident 18 revealed that Resident 18 chose the option that they Did not want CPR to be attempted should their heart stop beating. Record review of the Physician's Do Not Resuscitate (DNR) (A type of advance directive in which a person states that health care providers should not perform cardiopulmonary resuscitation (restarting the heart) if his or her heart or breathing stops) Order for the Medically Ill dated [DATE] for Resident 18 revealed the resident choice for DNR in the event of cardiac arrest. The form was signed by the physician on [DATE]. Interview on [DATE] at 12:05 PM with Medication Aide-D (MA-D) revealed that if MA-D found a resident not breathing with no pulse that MA-D would immediately let the nurse know. MA-D revealed that MA-D does not look up the resident code status to see if CPR should be started. MA-D revealed that MA-D is just responsible for letting the nurse know if the resident does not appear to be breathing or have a pulse. Interview on [DATE] at 12:06 PM with Registered Nurse-C (RN-C) revealed that if staff reports a resident not breathing or without a pulse, then RN-C would check the resident code status on the electronic health record profile page for the resident. RN-C confirmed that RN-C would determine if the resident wanted CPR or not by looking at the electronic health record profile page to determine the resident's code status. Interview on [DATE] at 12:09 PM with Resident 18 revealed that the resident chooses to be a DNR (the resident does not want staff to do CPR in the event of cardiac arrest) and that the resident has an advanced directive confirming their choice for DNR. Interview on [DATE] at 12:12 PM with the Assistant Director of Nursing (ADON) revealed that the resident's code status is on the resident profile page in the electronic health record. The ADON (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	revealed that the nurses and aides have a pocket cheat sheet that also lists the resident's code status. Record review of the undated and unlabeled staff pocket cheat sheet revealed that Resident 18's code status was identified as Full Code. Interview on [DATE] at 12:27 PM with the ADON confirmed that the electronic health record profile page for Resident 18 revealed Resident 18 to be a full code (CPR to be performed in the event of cardiac arrest). The ADON confirmed that the Physician's Do Not Resuscitate (DNR) Order for the Medically Ill for Resident 18 revealed that Resident 18 chose to be a DNR. The ADON confirmed that the code status on the electronic health record profile did not match Resident 18's choice for DNR. The ADON confirmed that in the event of cardiac arrest the staff reviewing the electronic health record profile page would have performed CPR against the wishes of Resident 18. The ADON revealed that the ADON would fix it. Interview on [DATE] at 12:36 PM with the facility Assistant Administrator (AA) revealed that the listing of Resident 18 as a full code was an oversight. The AA confirmed that Resident 18 chose to be a DNR. The AA revealed that the ADON did update the electronic health record and placed a red dot on the resident's door to signify the resident is a DNR. The deficient practice of advanced directive/code status reviews have been corrected [DATE] by implementing the following: .-The code status for (Resident 1) has been reviewed with resident, signed by resident, and faxed to [gender] primary physician for signature. -The code status for (Resident 18) has been updated on the PCC eMAR. The pocket care plan, and the sticker on the resident's room door to reflect the current signed code status. System Changes: -The advanced directives/code status will be verified utilizing a 2-step process, with second nurse reviewing the signed order and verifying the PCC eMAR, the pocket care plan, and the stocker on the resident's name plate accurately reflects the current signed code status order. -Education regarding the system changes as it relates to advanced directives/code status, were provided [DATE] to all licensed nurses on site and the social worker. Education will be provided to all licensed nurses on site at the next shift change and will provide continued education with the next staff meeting. Monitoring and Auditing: -All current residents code status/advanced directives will be audited by the interdisciplinary team for compliance weekly and documented on Risk Management template. -All new residents code status/advanced directives will be audited by the interdisciplinary team for compliance weekly and documented on risk meeting template. At the time of the survey, the violation was determined to be at the immediate jeopardy level J. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Based on observation, interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. Based on record reviews and interviews, the facility failed to ensure resident code status for life saving measures were accurate for all residents. This affected 2 (Resident 1 and Resident 18) of 23 sampled residents. The facility census was 23. [NAME] at Prairie Commons was notified on [DATE] at 1:43 PM of an Immediate Jeopardy (IJ) which began on [DATE]. The IJ was removed on [DATE] at 5:20 PM, as confirmed by surveyor onsite verification. Findings are: Record review of the facility policy Advanced Directives dated [DATE] stated the purpose of the policy was to recognize the Senior's rights to make decisions relating to their own medical care, including the right to accept or refuse treatment and the right to formulate an advanced directive (a document allowing a person to give directions about future medical care or to designate another person to make medical decisions if he or she should lose the ability to make decisions. consistent with state and federal regulations and the patient self-determination act (PSDA). A process to educate and inform seniors of their rights to formulate and advanced directive, to promote the senior's right to accept or refuse medical treatment to the extent allowed under state law and provide education regarding advanced directives. The procedure for the Advanced directives stated that upon admission staff would: 1.) provide services to the residents and family members or representatives with a copy of the statement of rights prepared by the Nebraska Department of Health and Human Services. 2.) Staff would identify if a senior had an Advanced Directive as well as their right to formulate one but not be required to do so. 5.) The admissions coordinator or social services staff would ensure the admission Application had been completed identifying the type of Advanced Directive, if any, the resident had, and if not available, request a copy. 7.) Copies of the Advanced directive would be maintained in the senior's clinical record- an electronic version would be in the electronic medical record. 8.) Upon admission the resident's Advanced Directive would be added to the resident care plan (facility plans of care that state how a patient wants to be cared for as well as interventions to assist with cares). Any Senior may revoke their advanced directive at any time without regard to the Senior's mental or physical condition. At that time, when a revocation happens, it is communicated to staff, the physician will be notified and the chance in advanced directive documented in the clinical record. The advanced directive will be removed from the clinical record. (continued on next page)

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F 0678

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

9.) A durable power of Attorney for Health Care will go into effect when the client's Power of Attorney has been invoked and determined to be incapable of making health care decisions. This determination is to be made by the attending physician and documented in the clinical record.

10.) The facility will honor any Senior's choice to decline treatment. The senior may not be treated against their will.

Record review of the undated policy and procedure CPR (Cardio-Pulmonary Resuscitation- a life saving measure for when one stops breathing or one's heart stops beating) stated Any client found unconscious without pulse and/or respirations will have CPR initiated immediately unless the client has a valid 'Do Not Resuscitate form on file. The procedure included the following instructions:

1.) When the client is found unconscious without pulse and respirations have been established, the first person to respond must confirm the resuscitation status by checking.

2.) After calling for assistance, CPR shall be initiated by certified responders at the scene.

6.) All nursing staff and medication aides to be current with CPR certification.

Record review of electronic medical records for all 23 residents living in the facility revealed that for Resident 1 and Resident 18, the electronic medical record (EMR) did not match the signed requests or code status of these two, individual residents. Resident 1 had a current code status of Do Not Resuscitate with a code status of Full Code which was signed upon admission [DATE]. Resident 18 had a newly signed code status of Do Not Resuscitate and the EMR showed Resident 18 as a Full Code.

A.

Record review of the admission Minimum Data Set (MDS- a standardized assessment tool used to evaluate the health status of residents in long-term care facilities certified to participate in Medicare or Medicaid which helps facilities provide better care, create care plans, and meet regulatory requirements) dated [DATE] revealed that Resident 1 was legally blind, had a Brief Interview for Mental Status (BIMS - a tool used to assess the cognitive status of residents and is scored from 0 (severe impairment) to 15 (cognitively intact)) score of 8, had no behavior issues, was used a wheelchair, had mobility issues due to Parkinson's, and had limited range of motion to both upper extremities, had diagnoses for diabetes, arthritis, Chronic Obstructive Pulmonary Disorder, macular degeneration, Parkinson's Disease, and frequently suffered from pain. Resident 1 took medications to control anxiety and depression, diuretics for edema, high blood pressure, and fluid retention, opioids for pain control, and antiplatelets to prevent blood clots.

Record review of the working Care Plan for Resident 1 revealed that the code status for Resident 1 was Do Not Resuscitate.

Record review of the Physician Orders for Life Sustaining Treatment (POLST) for Resident 1 was dated [DATE] and signed by Resident 1's Power of Attorney on [DATE]. The Advanced directive was then signed by the physician on [DATE]. This information revealed that Resident 1 had chosen to die a natural death and asked to be a DNR (do not attempt resuscitation). The resident wanted comfort focused treatment. The facility obtained a facsimile of this document on [DATE].

Record review of the Advanced Directive document dated [DATE] and signed by Resident 1 upon

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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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admission to the facility on [DATE] revealed the resident did have a living will and would provide a copy to the facility, did have a durable power of attorney and would provide a copy to the facility. The directive stated I do want cardiopulmonary resuscitation (CPR) should my heart stop beating. I understand that I will receive cardiopulmonary resuscitation and life sustaining treatment to the extent of the provider's ability. This was signed by Resident 1 on [DATE] at 7:17 PM and witnessed by the Assistant Administrator (AA) at the time of admission to the facility. Record review of Resident 1's online Electronic Medical Record on [DATE] revealed that the code status for Resident 1 was DNR. Record review of the daily nursing staff pocket care plan (a single sheet of paper used in daily report of all residents during staff change and report) revealed that Resident 1 was listed as a Full Code and wanted CPR. Observation of the name plate at the room entrance to the room of Resident 1 revealed there was a Red Dot on the door that indicated Resident 1 was to be a DNR and did not want CPR or life saving measures. Interview at 11:38 AM on [DATE] with Resident 1. My attorney signs most everything for me. But I would expect that I would be a full code because I would like to be transferred to the hospital to see if I could be saved. That's what I would want. Interview on [DATE] at 12:00 PM with Medication Aide (MA)-B, who revealed that if a resident becomes unconscious and needs life saving measures, then those residents who are full codes (want CPR) and those who do not want CPR (also called a DNR) are on a list. MA-B stated [gender] has everyone's code status memorized. When asked about Resident 1, [gender] did not know because MA-B rarely works with the residents in the south hall and works almost primarily in the north hall. MA-B did look at the door and stated that there is a Red Dot on the name plate at the door entrance for Resident 1 and that signifies that individual would be a DNR. Looking at the other doors in the south hall, where MA-B worked on [DATE], MA-B was able to point to several doors that had red dots on the name plates at the entrance and a couple doors with a green dot on the name plate. MA-B stated that the green dots mean those individuals living in those rooms are a full code and would want to have CPR and life saving measures. Sometimes the new residents may not have a red or green dot on their door nameplate for a few days. We can also look in the Electronic medical record, but the first thing medication aides and nursing assistants must do is to tell the charge nurse. Interview on [DATE] at 12:10 PM with Licensed Practical Nurse (LPN)-A stated that the best place to look to see if a resident is a DNR or a Full Code is in the Electronic Medical Record (EMR) as it is posted on the bar at the top of each resident's page. We also make sure there is a red or green dot on the name plate at the entrance door of every room. This gives us the information at a quick glance. [NAME] dots mean full code and those residents want CPR. Red dots mean DNR and do not want to have life saving measures in the event something happens to them. Interview on [DATE] at 12:25 PM with the Director of Nursing (DON) stated that everyone is a full code whether anything is signed or not until the doctor's sign the orders. After the doctor signs the orders, then the resident is either a DNR or a Full Code. This information should be listed in every resident's Care Plan. In the EMR, the information is stated at the top of the page for each resident and is on all pages. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview on [DATE] at 12:30 PM with the Assistant Director of Nursing (ADON). Confirmed the Code status signed on [DATE] for Resident 1 does not match the code status on the EMR. Resident 1 requested to be a full code. The EMR stated Resident 1 was a DNR. Interview on [DATE] at 12:31 PM with the DON who also confirmed the code status for Resident 1 does not match on the EMR and on the Code document signed upon admission by Resident 1.

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Licensure Reference Number 175NAC 12-006.09(H)(iii)(2)

Based on observation, record review, and interview the facility failed to ensure documentation that resident wounds were evaluated and monitored at least weekly as required for 1 of 1 residents reviewed (Resident 16). This prevented staff from determining if the wound condition was healing or worsening. The facility census was 23.

Findings are:

Record review of the facility Wound and Skin Care Management dated 11/11/23 revealed that the facility will provide care to promote prevention and management of skin injuries. Weekly evaluations of skin impairment, including measurements, will be completed in the EMR (electronic medical record) (the electronic health record).

Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 4/14/25 for Resident 16 revealed that Resident 16 admitted into the facility on 4/8/25. The MDS revealed that Resident 16 had an unstageable pressure ulcer [a wound/bedsore where the true depth cannot be determined because the base of the ulcer is covered by slough (yellow, tan, grey, green, or brown moist stringy tissue that is essentially dead tissue that needs to be removed to allow the wound to heal properly) and/or eschar (a tan, brown, or black thick, dry crust of dead tissue that forms over a wound)] that was present on admission.

Record review of the current care plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 4/28/25 for Resident 16 revealed that Resident 16 had a pressure ulcer on the left heel. Interventions included monitor/document location, size and treatment of the skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, to the physician. Interventions included weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate (any liquid that drains from a wound) and any other notable changes or observations.

Observation on 4/30/25 at 2:42 PM in the room of Resident 16 revealed that the Director of Nursing (DON) requested permission to look at the resident's left heel. The DON uncovered the resident's left foot and removed the tan gripper sock from the foot. An approximately 1 centimeter (cm) long x 2 cm wide tan/brown raised eschar was present on the back of the left heel.

Observation on 5/1/25 at 9:41 AM in the room of Resident 16 revealed that Resident 16 sat on the edge of the bed. The resident had bare feet. The wound on the left heel measured approximately 1 cm x 2 cm per visual measurement. The wound base was a raised eschar that was brown/tan in color. A dark red/brown skin discoloration was present on the upper wound edge above the eschar from the 1 o'clock to 3 o'clock position of the wound. The discoloration was approximately 0.6 cm in length and 1.5 cm in width.

Interview on 4/30/25 at 1:59 PM with Licensed Practical Nurse-F (LPN-F) revealed that the facility uses an iPhone to picture and measure resident wounds. LPN-F revealed that the information is transferred to the resident electronic medical record somewhere.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/30/25 at 2:02 PM with the facility Assistant Director of Nursing (ADON) revealed that wound monitoring and measurements may be under the skin and wound tab, the skin check, or skin evaluation in the resident's electronic medical record. Record review of the Clinical admission evaluation for Resident 16 dated 4/8/25 revealed a skin note that Resident 16 had left heel eschar prior to hospitalization. The Clinical admission had no documentation of the measurements or description of the left heel pressure ulcer with eschar. Record review of the Skin Check for Resident 16 dated 4/16/25 revealed that the left heel skin issue was documented as bruising. The Skin Check had no documentation of the left heel pressure ulcer. The Skin Check had no documentation of the measurements or description of the left heel pressure ulcer with eschar. Record review of the Skin and Wound Total Body Skin assessment dated [DATE] for Resident 16 revealed no documentation of the left heel pressure ulcer. The Skin and Wound Total Body Assessment had no documentation of the measurements or description of the left heel pressure ulcer with eschar. Record review of the progress note dated 4/8/25 at 3:38 PM for Resident 16 revealed that Resident 16 had a left heel wound with eschar that was present prior to hospitalization. The progress note revealed that it contained no documentation of the measurements or description of the left heel pressure ulcer with eschar. Record review of the medication administration record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) for the month of April 2025 for Resident 16 revealed that staff documented the application of povidone iodine (an antiseptic used for skin disinfection and wound care) to the left heel once daily beginning on 4/9/25 through 4/30/25. The MAR revealed that it contained no documentation of the size or description of the left heel pressure ulcer with eschar. Record review of the electronic medical record for Resident 16 revealed no measurements or descriptions of any evaluation of the left heel wound of Resident 16. Interview on 4/30/25 at 2:44 PM with the DON confirmed that the wound on the left heel of Resident 16 was currently present and not healed. The DON confirmed that the expectation is for ongoing monitoring and documentation of any unhealed resident wounds. The DON was asked by this surveyor to locate and provide the weekly documentation of the left heel wound measurements and description of the wound. Interview on 5/1/25 at 11:06 AM with the facility DON confirmed that the facility did not have any documentation that evaluations or measurements of the left heel wound of Resident 16 were completed as required.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NA 12-006.10(D) Based on record reviews, observations and interviews, the facility failed to ensure medication error rates were not 5% or greater (27 opportunities with 10 errors resulted in an error rate of 37.04%). This affected 3 (Residents 1, 5, and 123) of 4 residents sampled. The facility census was 23. Findings are: Record review of the undated Medication Error Policy revealed it is the facility policy to ensure residents are free from significant medication errors and that the facility maintains a medication error less that 5%. Medication errors included the following errors: Wrong time Omission of a medication Record review of the undated facility medication times revealed that 6:00 AM to 11:00 AM [NAME] is called AM 6a-11a. This is the time period any of the scheduled morning medications can be given to residents except those medications that have a specific time indicated by pharmacy or a physician. A. Record review of the Electronic Medical Record for Resident 1 revealed an order for carbidopa/levodopa (a medication for Parkinson's Disease) 25 milligrams (mg)/100 (mg) was scheduled for a specific time three times daily at 6:00 AM, 1:00 PM, and 7:00 PM. This order was not signed off by the nurse (meaning it had not been charted as given). Observation on 04/30/2025 at 8:14 AM of Licensed Practical Nurse (LPN-F) who prepared and administered medications to Resident 1. The medication carbidopa/levodopa 25/100 mg which was scheduled to be given at 6:00 AM was administered at 8:15 AM to Resident 1 who was seated at the table eating breakfast. Interview on 04/30/2025 at 8:20 with LPN-F who confirmed the medication Carbidopa/Levodopa 25/100 mg was administered late to Resident 1. B. Record review the EMAR on 4/30/2025 at 8:25 AM of Resident 123 had all medications scheduled for administration at 6:00 AM. These medications included the following: aspirin 81 mg enteric coated one daily (QD), docusate 100 mg twice daily (BID) , Eliquis (an anticoagulant to prevent blood clots) 2.5 mg BID, lisinopril for high blood pressure) 10 mg QD, vitamin D3 2000 Units, Lactulose 10 mg/15 ml, Miralax 17 grams QD, and Men's Gummy Vitamin QD. Observation on 04/30/2025 at 8:25 AM of LPN-F who prepared and administered medications to Resident 123. The medications were aspirin 81 mg enteric coated one daily (QD), docusate 100 mg BID, Eliquis 2.5 mg BID, lisinopril 10 mg QD, vitamin D3 2000 Units, Lactulose 10 mg/15ml, Miralax 17 grams QD, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tabitha at Prairie Commons	3490 Ewoldt Street 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)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and Men's Gummy Vitamin QD. Interview on 04/30/2025 at 8:35 AM with LPN -F who confirmed that officially all of these medications were given late because all of the medications were scheduled to be given at 6:00 AM. However, we (the facility) use [NAME] times (a time used to cover all morning medications from 8 AM to 11 AM) and the scheduled times in the electronic medication administration record (EMAR) were not entered correctly. Somebody needs to fix that in the computer. Interview on 04/30/2025 at 8:40 AM with the Assistant Director of Nursing (ADON) confirmed the times that are in the computer are not correct. But, at that time the medications did have a scheduled time of 6:00 AM and they were given late. The ADON was going to contact the pharmacy and have the changes made immediately to fix this error in the system because nobody in the facility could change the times in the online system. Interview on 05/01/2025 at 10:30 AM with Consulting Pharmacist (PharmD) who revealed that the facility does use [NAME] times for medication administration. However, PharmD also confirmed the medications were given late and a staff member or nurse should have contacted the pharmacy on Saturday when this first occurred to let the pharmacy know that the times were incorrect. Because they didn't contact the pharmacy the medications should have been given at 6:00 AM as indicated on the EMAR. C. A review of the EMAR for Resident 5 revealed there was an order for pantoprazole 40 mg daily with a specific administration time of 7:30 AM that was not given. Observation on 04/30/2025 at 8:44 AM as LPN-F looked though the remaining medications that needed to be given for the morning. Resident 5 had pantoprazole 40 mg scheduled for 7:30 AM that was not given. Interview on 04/30/2025 at 8:44 AM with LPN-F who stated Resident 5 had not been out to the dining room for breakfast yet so had not received the pantoprazole that was scheduled. So yes, this is a medication error too. Interview on 04/30/2025 at 8:45 AM with the Assistant Director of Nursing (ADON) confirmed the times that medications that are in the computer with a specific time and not [NAME] time are to be given at that time. ADON confirmed the pantoprazole was a medication error. Interview on 04/30/2025 at 08:45 AM confirmed with LPN-F that Resident 123's medications needed to be changed to [NAME] time. The times were placed by pharmacy and so they were officially all late. LPN-F confirmed Resident 1's carbidopa/levodopa was late and should have been given at 0730. LPN-F confirmed that because Resident 5 had not been out of their room yet, Resident 5 had not been given the early morning dose of pantoprazole.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285307	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Tabitha at Prairie Commons		STREET ADDRESS, CITY, STATE, ZIP CODE 3490 Ewoldt Street Grand Island, NE 68803	

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 1-005.06(D) Based on observation, record review, and interview; the facility failed to ensure staff performed hand hygiene to prevent the potential for cross contamination while assisting residents who were eating meals in the dining room. This had the potential to affect 9 (Residents 1, 2, 3, 6, 10, 11, 12, 13, and 123) of 9 sampled residents. The facility census was 23. Findings are: A record review of the facility's Hand Hygiene policy with a review date of 10/26/2024 revealed the purpose of the policy was to prevent and control the spread of infections to the best of the facility's abilities. The procedure stated; 1. Alcohol-based hand rub is recommended in all situations except when hands are visibly soiled or when caring for a resident with certain known infections. 3. Food and Nutrition staff or staff that are handling food must wash hands with soap and water. 6. The facility strives to provide feedback regarding hand hygiene. 7. Supplies to adhere to hand hygiene practices are readily accessible within resident care areas. An observation on 04/30/25 at 8:45 AM of Licensed Practical Nurse (LPN)-G who assisted residents in the dining room with breakfast. LPN-G went first to Resident 13 to assist with breakfast. Resident 13, who frequently eats with hands and not with utensils, was assisted by LPN-G. LPN-G stood behind Resident 13 and helped this resident pick up breakfast finger foods so Resident 13 would start eating. Once Resident 13 started eating, LPN-G went to Resident 6, touched both shoulders of Resident 6 and assisted this resident. LPN-G then assisted Resident 1 with removing their clothing protector and carried the soiled clothing protector to the dirty linens in the dining area. LPN-G continued assisting residents. LPN-G checked on Resident 122 and Resident 22 and touched the shoulders of each resident. Following this, LPN-G walked to the food service window and used alcohol-based hand sanitizer (ABHS) for the first time. LPN-G then assisted Resident 13, then Resident 1 and then Resident 3 before using ABHS again. An interview on 04/30/25 at 8:55 AM with the Assistant Director of Nursing (ADON) who confirmed LPN-G had not used hand hygiene between residents while assisting at breakfast. ADON revealed LPN-G was orienting to the facility. An interview on 04/30/2025 at 9:05 AM with LPN-G confirmed they had not used ABHS between each resident. LPN-G confirmed that usually there is a bottle of alcohol in (gender) pocket and they didn't have that little bottle today.