STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46863 Based on interviews, record review, and facility policy review, the facility failed to invite 1 (Resident #45) of 39 sampled residents whose care plans were reviewed to attend their care conferences. Findings included: A review of a facility policy titled, Interdisciplinary Plan of Care, last modified on 02/03/2021, revealed, Purpose 1. To facilitate an interdisciplinary approach to resident care which is aimed at meeting the many and varied needs of the resident. 2. To promote collaboration of the various disciplines. Procedure The resident's interdisciplinary plan of care is developed and revised through a collaborative effort of an Interdisciplinary Team (IDT), the resident and the resident's guardian/DPOA [durable power of attorney] or representative of his/her choice. The policy further specified, 3. The disciplines discuss their assessments of the resident's needs. The members of the Interdisciplinary Team, the resident, and their family/guardian or representative of his/her choice are encouraged to be actively involved in identifying needs and the planning of care. A review of an Admission Record revealed the facility admitted Resident #45 to the facility on [DATE] with diagnoses that included chronic atrial fibrillation, unspecified intellectual disabilities, Tourette's disorder, and major depressive disorder. A review of an annual Minimum Data Set (MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes.), with an Assessment Reference Date (ARD) of 02/12/2024, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of Resident #45's comprehensive care plan revealed a Focus area, initiated on 05/25/2022 and revised on 02/14/2024, that indicated the resident was at risk for self-care deficit due to decreased mobility, intellectual disability, incontinence, and chronic pain. An intervention initiated on 05/25/2022 directed staff to encourage the resident to participate in planning day to day care. During an interview on 04/22/2024 at 11:25 AM, Resident #45 stated they had not been asked to attend their care conferences. Resident #45 said their family member participated in care conferences via phone calls, but the resident also wanted to attend. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285019	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #45's Multidisciplinary Care Conference documents, dated 06/01/2023 at 9:22 AM, 08/28/2023 at 11:06 AM, 11/30/2023 at 9:46 AM, and 03/04/2024 at 9:41 AM, revealed no documentation that indicated Resident #45 attended any of their care conferences. A review of social services Progress Notes, for the timeframe from 05/25/2023 to 04/23/2024 revealed documentation that the resident's responsible party was invited to the resident's care conferences; however, there was no documentation indicating the resident had been invited to attend. During an interview on 04/25/2024 at 9:30 AM, the Chief Nursing Officer (CNO) revealed it was important for residents to be invited to their care plan meetings so the residents could have a voice in their own care. The CNO stated they expected care plan meetings to be held quarterly and after any significant change in condition. The CNO said they expected residents and their family members to be invited. During an interview on 04/25/2024 at 2:50 PM, Registered Nurse (RN) Y revealed the facility conducted care conferences within 30 days of admission and on a quarterly and annual basis. RN Y said it was mandatory for staff to invite the residents to attend their care conferences. During an interview on 04/26/2024 at 9:28 AM, Social Worker (SW) Z revealed they sent out care conference invitations by way of mail to the resident's responsible party and entered a progress note. SW Z said they had not invited Resident #45 to their care conferences and stated that there had been times that residents were invited to care plan meetings, and it had not gone well. During an interview on 04/26/2024 at 11:25 AM, the Assistant Director of Nursing (ADON) revealed they expected residents to be invited to their care conferences. The ADON indicated residents should be invited to their care conferences to state their concerns, because the residents were the best voice of what was important to them. During an interview on 04/26/2024 at 12:19 PM, the Administrator revealed they expected residents to be invited to their care conferences, regardless of whether they had a responsible party or guardian. The Administrator said residents should be involved in their care plan because it affected them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. 19186 Based on observations, interviews, and facility policy review, the facility failed to ensure the most recent survey results were readily accessible to all residents to review and that posted notices of the availability of the survey results were in an area of the facility that was prominent and accessible to the public. This had the potential to affect all residents that resided in the facility. Findings included: A review of a facility policy titled Availability of Survey Results, last modified by the facility on 08/24/2023, revealed, Policy: The purpose of this policy is to uphold a resident's right to examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. Definitions: Place readily accessible is a place (such as a lobby or other area frequented by most residents, visitors, or other individuals) where individuals wishing to examine survey results do not have to ask to see them. Results of the most recent survey means the Statement of Deficiencies (Form CMS [Center for Medicare and Medicaid] 2567) and the Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigation(s). Policy Explanation and Compliance Guidelines: 1. A readable copy of our company's most recent federal and/or state survey report and plan of correction for any identified deficiencies is maintained in a 3-ring loose-leaf binder titled Results of Most Recent Survey. 2. The survey binder is located (in the main lobby) and is available for review by interested persons who wish to review information relative to our company's compliance with federal or state rules, regulations and guidelines governing our company's operation. 3. A representative of management is assigned the responsibility of making weekly inspections of the survey binder to ensure that the binder contains current information, is in its designated area(s), and is readily accessible without one having to ask staff members for the information. 4. The facility will maintain reports of any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility. This information will be available for any individual to review upon request. Further review revealed, 6. Signs identifying the availability and location of our survey binder and availability of previous survey results are posted throughout the building and public bulletin boards. During the recertification and complaint survey from 04/22/2024 through 04/26/2024 there were no signs observed posted in the building indicating where the survey results were located. The facility had 10 different units spread throughout the building on different floors and some of the units are locked. During an interview on 04/24/2024 at 2:54 PM, the Compliance Officer (CO) revealed that the survey book was located on the ground floor in the lobby at the desk where the security guards were seated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	During an interview on 04/24/2024 at 4:29 PM, the CO revealed that the survey book was located downstairs, and it was the incorrect notebook. The CO stated that the notebook was supposed to be a three-inch ring binder book with their business card on the front. The CO stated that they were responsible for updating the survey notebook with the latest CMS-2567. The CO confirmed that the survey book did not contain the latest recertification survey from 05/16/2023. During an interview on 04/25/2024 at 2:33 PM, the Administrator revealed that they expected the survey book to be updated with the latest survey. The Administrator stated that the CO was responsible for checking the book monthly. The Administrator stated that the facility had 10 units and that if a resident wanted to see the survey results, staff could go downstairs and get the survey notebook. The Administrator stated that in the past, the facility had posted signs that indicated where the survey book was located. The Administrator stated that the facility was renovated, and the signs were not put back up. The Administrator stated that the survey notebook was put in a central location because when they were on the units, they would disappear. During an interview on 04/26/2024 at 11:21 AM, the Assistant Director of Nursing (ADON) revealed that the survey notebook was available in the lobby on the desk and the CO's office. The ADON revealed that they would expect a survey notebook to be on each unit available to residents and their family members. The ADON stated that there was a handful of residents who would ask how the survey went. The ADON stated that none of the residents had ever asked them for the recent survey results. The ADON stated that, to their knowledge, there were no signs on the units posted to indicate where the survey results notebook was located.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 37683 Based on record review, interviews, and facility policy review, the facility failed to promptly notify a resident's hospice service provider of a change in condition for 1 (Resident #231) of 2 sampled residents reviewed for change in condition. Specifically, Resident #231's hospice and primary care provider were not notified of an abnormal culture and sensitivity (C&S) lab result until a week after it was reported to the facility. As a result of this delayed notification, the hospice provider did not order an antibiotic to treat Resident #231 until a week after the abnormal C&S lab result was reported to the facility. Findings included: A review of a facility policy titled Guidelines for Physician Notification, last modified by the facility on 09/28/2020, revealed under the section titled Physician Notification, the column titled Next Working Day indicated that physician notification by the next working day was recommended in the guidelines for laboratory tests, including a Urine Culture and Sensitivity revealing > [greater than] 100,000 colony count without any symptoms. Further review revealed under the section titled Physician Notification, the column titled Immediate indicated that immediate notification of the physician was recommended in the guidelines for laboratory tests, including a Urine Culture and Sensitivity revealing >100,000 colony count with a urinary pathogen with symptoms and no treatment. A review of an Admission Record indicated the facility admitted Resident #231 on 11/13/2023 with diagnoses that included neurocognitive disorder with Lewy bodies, dementia in other diseases classified elsewhere, adult failure to thrive, benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine. The admission Minimum Data Set (MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes.), with an Assessment Reference Date (ARD) of 11/20/2023, revealed Resident #231 had a Brief Interview for Mental Status (BIMS) score of 08, which indicated the resident had moderate cognitive impairment. A review of Resident #231's Care Plan revealed a Focus area initiated on 11/21/2023 that indicated the resident had an indwelling catheter for benign prostatic hyperplasia with retention. Interventions directed staff to monitor, record, and report to the medical doctor signs and symptoms of a urinary tract infection (UTI). Further review revealed a Focus area initiated on 11/21/2023 that indicated the resident had a terminal prognosis and was receiving hospice services. Interventions directed staff to work cooperatively with the hospice team to ensure the residents spiritual, emotional, intellectual, physical and social needs were met. A review of Resident #231's urine culture and sensitivity laboratory results reported on 11/23/2023 revealed there were over 100,000 colony-forming units per milliliter of Enterococcus faecalis. The report revealed a handwritten note written by Advanced Practice Registered Nurse (APRN) G that revealed noted 11/30/23 [2023]. Further review revealed a handwritten note that stated Macrobid (an antibiotic) 100 milligrams (mg), one capsule twice a day for five days, was started and to please send to the hospice service provider for review. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #231's urine culture and sensitivity laboratory results reported on 11/23/2023 revealed there were over 100,000 colony forming units per milliliter of Enterococcus faecalis. The report revealed a handwritten note that stated the results were faxed to the hospice service provider on 11/30/2023 at 3:15 PM. A review of Resident #231's nursing Progress Note, dated 11/27/2023 at 10:40 PM, revealed that lab results were placed in the APRN book along with a C&S. A review of Resident #231's nursing Progress Note, dated 11/30/2023 at 3:00 PM, revealed that the results for a C&S were sent over to the hospice team that day. A review of Resident #231's nursing Progress Note, dated 11/30/2023 at 5:15 PM, revealed that the facility contacted the hospice service provider for a faxed prescription for an antibiotic for the resident's UTI. The note revealed the facility also sent out a fax of the nurse practitioner's recommendation for their review. A review of Resident #231's Hospice Physician Order dated 11/30/2023 at 5:15 PM revealed that the Doctor of Osteopathic Medicine (DO) H wrote an order for Macrobid 100 mg twice daily for five days. A review of Resident #231's Order Summary Report with an order date range of 11/20/2023 to 02/09/2024 revealed an order with a start date of 11/30/2023 for Macrobid oral capsule 100 mg by mouth two times a day for five days. A review of Resident #231's nursing Progress Note, dated 12/01/2023 at 10:48 AM, revealed a new order to start Macrobid 100 mg by mouth twice daily for five days. During an interview on 04/24/2024 at 10:51 AM, Registered Nurse (RN) I stated that for residents on hospice, abnormal lab results were sent to the hospice team. During an interview on 04/24/2024 at 11:49 AM, the hospice service provider's Manager of Clinical Services revealed that the hospice service provider did not receive Resident #231's abnormal lab results until 11/30/2023. During an interview on 04/26/2024 at 8:26 AM, RN I confirmed that the facility received the abnormal C&S laboratory results for Resident #231 on 11/23/2023. RN I also confirmed that there was no specific documentation that indicated the hospice service provider was alerted of the abnormal C&S laboratory results prior to 11/30/2023. RN I stated that the facility's APRN had to order the antibiotic because it was not done by the hospice service provider. During an interview on 04/26/2024 at 9:14 PM, DO H revealed they would not have become aware of Resident #231's abnormal C&S until 11/30/2023 because the standard practice would have been to immediately act on it. During an interview on 04/26/2024 at 11:01 AM, the Administrator revealed that the facility staff should notify physicians of abnormal labs immediately. The Administrator stated if the facility staff notified the physician of an abnormal lab but there was no response, the facility staff would follow up within 48 to 72 hours or sooner if the clinical situation were urgent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/26/2024 at 11:10 AM, the Assistant Director of Nursing (ADON) stated their expectation was for abnormal laboratory reports to be reported to the provider within 24 hours. The ADON stated if the provider did not respond within two hours, the expectation was that they escalated to another provider above the one that was contacted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 46194 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure call lights were within reach for 2 (Resident #101 and Resident #487) of 2 residents observed for the use of call lights. Findings included: A review of a facility policy titled Call Lights: Accessibility and Response, last modified by the facility on 04/24/2024, revealed, 5. Staff will ensure the call light is within reach of resident and secured, as needed. 6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. A. A review of Resident #487's Admission Record revealed the facility admitted the resident on 06/23/2023 and readmitted the resident on 04/17/2024. According to the Admission Record, the resident had a medical history that included diagnoses of a history of falling and difficulty in walking. A review of an admission Minimum Data Set (MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes.), with an Assessment Reference Date (ARD) of 04/23/2024, revealed Resident #487 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS indicated the resident was dependent on staff to stand from a sitting position and with chair/bed-to-chair transfers. A review of Resident #487's Care Plan revealed a Focus area initiated on 04/25/2024 that indicated the resident had an activities of daily living (ADL) self-care performance deficit. Intervention directed staff to encourage the resident to use the bell (call light) for assistance. During an observation and interview on 04/22/2024 at 9:32 AM, Resident #487 was observed eating with their meal tray on the bedside table in their room. Resident #487 was sitting at the foot of the bed in a recliner chair. The call light was at the head of the bed, between the mattress and the headboard, lying on the floor and not within reach of the resident. Resident #487 stated they could not walk without assistance and asked the surveyor if they would hand them the call light. During an observation and interview on 04/22/2024 at 9:48 AM, Nursing Assistant (NA) D revealed Resident #487 was dependent on staff to get up and ready for the day. NA D stated the resident was dependent on staff for transfers, and staff used the sit-to-stand mechanical lift to transfer the resident. NA D stated the resident was able to use the call light to call staff for their needs, and the resident's call light should be within reach. NA D entered Resident #487's room and was observed to get Resident #487's call light out from behind the bed. NA D stated the call light was not within reach and the call light should have been within reach. NA D stated all staff were responsible for ensuring the call light was within reach. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER: Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 4102 Woolworth Avenue Omaha, NE 68105	

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/23/2024 at 3:45 PM, Resident #487 revealed they would like to have a clip on their call light because the call light falls on the floor at night, and they have had a difficult time reaching the call light when it fell to the floor. During an interview on 04/25/2024 at 2:34 PM, Licensed Practical Nurse (LPN) E revealed call lights should be within reach, and some residents have clamps that help secure the call light to the residents' blankets. LPN E stated staff should check to ensure call lights were within reach during rounds. LPN E stated Resident #487's call light did not have a clip. LPN E stated they did not know what happened to the clip. LPN E stated Resident #487 had the ability to use their call light. B. A review of Resident #101's Admission Record revealed the facility admitted the resident on 11/16/2023 with diagnoses that included muscle weakness and a history of falls. A review of a quarterly Minimum Data Set (MDS), with an Assessment Reference Date of 02/26/2024, revealed Resident #101 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The MDS indicated the resident needed substantial/maximal assistance from staff with rolling from left to right and was dependent on staff for chair/bed-to-chair transfers. A review of Resident 101's care plan revealed a Focus area initiated on 12/05/2023 that indicated the resident had an activities of daily living (ADL) self-care performance deficit. Interventions directed staff to encourage the resident to use the bell (call light) for assistance. During an observation and interview on 04/22/2024 at 11:36 AM, Resident #101 was observed in bed with the call light lying on the floor beside the bed. Resident #101 stated that they wanted to put their head of bed up and needed help to call someone to find their remote. During an interview on 04/22/2024 at 11:48 AM, Nursing Assistant (NA) F revealed Resident #101 was not able to get up on their own. NA F stated the resident had the ability to use the call light. NA F stated the call light should be within reach. NA F stated the call light was hard to keep on the bed due to no rails on the bed to secure the call light. NA F stated the call light was on the floor, and they were not sure if there were any devices to secure the call light to the bed or the resident's covers. During an observation on 04/24/2024 at 10:15 AM, Resident #101's call light was noted on the floor. Resident #101 proceeded to look for the call light and was trying to reach for it on the floor from their bed. There was a housekeeper in the room, and the housekeeper picked it up off the floor for the resident. During an interview on 04/25/2024 at 2:34 PM, LPN E revealed they went into Resident #101's room earlier in the day, and the call light was on the floor. LPN E stated the call light had to be put back in reach. LPN E stated they were not sure what happened to the clip on the call light. LPN E stated Resident #101 was able to use their call light. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/25/2024 at 3:19 PM, the Administrator revealed call lights should be within reach of the resident. The Administrator stated in March, clips were ordered to replace the clips on the call lights to help secure the call lights to ensure they were within reach. During an interview on 04/25/2024 at 3:27 PM, the Chief Nursing Officer (CNO) revealed call lights and personal items should be within reach. The CNO stated the facility on 03/19/2024 evaluated the need for clips to secure call lights and remotes. The CNO stated these clips end up missing or broken over time. The CNO stated the clips were ordered and were in the building. The CNO stated the remote clips engineering would need to install, but the call light clips could be installed by the floor staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. 22445 Based on interviews, record review, and facility policy review, the facility failed to ensure new Level I Preadmission and Resident Reviews (PASRRs) were completed after residents were diagnosed with new mental illness diagnoses and prescribed psychotropic medications for 2 (Resident #12 and Resident #74) of 5 sampled residents reviewed for PASRR requirements. Findings included: A review of a facility policy titled, Pre-Admission Screening and Resident Review (PASSR), last modified on 12/12/2018, revealed, With any significant change in status or newly evident or possible serious mental disorder or intellectual disability or related condition, a new PASRR Level I screen will be completed for any resident identified per a Level II screen as requiring specialized services. Any changes will be promptly reported to the State mental health authority or State intellectual disability authority as indicated. A. A review of an Admission Record revealed the facility admitted Resident #12 on 06/26/2008. According to the Admission Record, the resident had a medical history that included diagnoses of traumatic brain injury (onset date 02/07/2022), unspecified psychosis not due to a substance or known physiological condition (onset date 02/07/2022), bipolar disorder (onset date 02/07/2022), anxiety disorder (onset date 02/07/2022), and unspecified moderate dementia with agitation (onset date 10/01/2022). A review of Resident #12's Level I PASRR, dated 07/21/2008, revealed the question regarding whether the resident had a serious mental illness, including Psychotic/Delusional Disorder and Bipolar Disorder, was answered, No. The question regarding whether the resident had any mental disorders, including Anxiety Disorder, was answered, No. Resident #12's Level I PASRR also reflected the resident was not prescribed or had not been prescribed within the prior six months any psychoactive (mental health) medications. The section of the Level I PASRR titled, Determination and Outcome indicated the resident had a closed head injury at the age of 27 and had no diagnosis of mental illness, so the outcome was Negative, and a Level II was not required. A review of a quarterly Minimum Data Set (MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes.), with an Assessment Reference Date (ARD) of 03/01/2024, revealed Resident #12 had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident was cognitively intact. Per the MDS, the resident had active diagnoses at the time of the assessment that included non-Alzheimer's dementia, traumatic brain injury, anxiety disorder, bipolar disorder, and psychotic disorder. The MDS indicated Resident #12 had other behavioral symptoms not directed toward others one to three days during the seven-day assessment look-back period and received antipsychotic, antianxiety, and antidepressant medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER: Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 4102 Woolworth Avenue Omaha, NE 68105	

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident #12's Order Summary Report, listing active orders as of 04/23/2024, revealed an order started on 05/03/2022 for aripiprazole 20 milligrams (mg), one tablet orally one time a day related to bipolar disorder, an order started on 03/26/2023 for Ativan oral tablet 1 mg, one tablet by mouth two times a day related to bipolar disorder, an order started on 05/03/2022 for escitalopram 10 mg, one tablet orally one time a day related to generalized anxiety disorder, an order started on 05/03/2022 for escitalopram 20 mg, one tablet orally one time a day related to generalized anxiety disorder, and an order started on 05/03/2022 for risperidone 3 mg, one-half tablet orally two times a day related to bipolar disorder. During an interview on 04/24/2024 at 1:14 PM, the Admissions Clinical Liaison (ACL) said they were responsible for PASRRs. The ACL stated their responsibilities included making sure all residents had a PASRR on admission and ensuring the PASRRs included the correct information. The ACL stated if a resident had a change in condition, including additional diagnoses or medications, the staff were to inform them, and a new PASRR would be submitted. The ACL stated if mental illness diagnoses were added after Resident #12's admission, a new PASRR should have been submitted to the state for review. The ACL stated they were working in the facility in 2022 but was unaware Resident #12 was diagnosed with new mental illnesses. The ACL stated Resident #12 should have had a new PASRR submitted for review that reflected their new mental illness diagnoses. During an interview on 04/25/2024 at 9:28 AM, the Chief Nursing Officer (CNO) stated they expected PASRRs to be completed by the ACL when new mental illness diagnoses were added. The CNO stated this would be important to help determine the level of care the resident required and to make sure the facility could provide the care the resident needed. During an interview on 04/25/2024 at 2:13 PM, the Administrator reviewed Resident #12's Level I PASRR from 2008 and acknowledged the PASRR did not reflect Resident #12's psychotropic medications and psychiatric diagnoses. B. A review of an Admission Record revealed the facility admitted Resident #74 on 04/16/2021 and most recently readmitted the resident on 06/09/2022. According to the Admission Record, the resident had a medical history that included diagnoses of alcohol dependence with alcohol-induced persisting dementia (onset date 02/11/2022), major depressive disorder (onset date 02/11/2022), anxiety disorder (onset date 02/11/2022), and delusional disorders (onset date 03/10/2023). A review of Resident #74's Level I PASRR, dated 09/24/2019, revealed the form indicated, No mental health diagnosis is known or suspected, and the resident did not receive antidepressants, mood stabilizers, antipsychotics, or other mental health medications at the time of the Level I PASRR or within the six months prior. The form reflected Resident #74 had an alcohol dependency or abuse disorder and dementia. The Section of the Level I PASRR titled, Outcome, indicated there was no evidence of a PASRR condition of a serious behavioral health condition and specified, If changes occur or new information refutes these findings, a new screen must be submitted. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285019	A. Building B. Wing	04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/02/2024, revealed Resident #74 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. Per the MDS, the resident had active diagnoses at the time of the assessment that included non-Alzheimer's dementia, anxiety disorder, depression, alcohol dependence with alcohol-induced persisting dementia, and delusional disorder. The MDS indicated Resident #74 received antipsychotic, antianxiety, and antidepressant medications during the seven-day assessment look-back period. A review of Resident #74's comprehensive care plan revealed a Focus area, initiated on 06/01/2023 and revised on 11/08/2023, that indicated the resident used psychotropic medications for anxiety, depression, and delusional disorder. An additional Focus area, initiated on 12/12/2022, indicated Resident #74 had a mood problem related to major depressive disorder. A review of Resident #74's Order Summary Report, listing active orders as of 04/24/2024, revealed an order started on 05/03/2022 for lorazepam 0.5 milligrams (mg), one-half tablet by mouth two times a day related to anxiety disorder, an order started on 10/06/2022 for mirtazapine 30 mg, one tablet by mouth at bedtime for major depressive disorder, and an order started on 02/10/2023 for Abilify 2 milligrams (mg), give one tablet by mouth in the morning for delusions related to delusional disorder. During an interview on 04/24/2024 at 1:14 PM, the Admissions Clinical Liaison (ACL) revealed they were responsible for PASRRs. The ACL stated their responsibilities included making sure all residents had a PASRR on admission and ensuring the PASRRs included the correct information. The ACL stated if a resident had a change in condition, including additional diagnoses or medications, the staff were to inform them, and a new PASRR would be submitted. The ACL stated a new PASRR should have been submitted for Resident #74 but said they were unaware of the resident's diagnoses. During an interview on 04/25/2024 at 9:28 AM, the Chief Nursing Officer (CNO) stated they expected PASRRs to be completed by the ACL when new mental illness diagnoses were added. The CNO stated this would be important to help determine the level of care the resident required and to make sure the facility could provide the care the resident needed. During an interview on 04/25/2024 at 2:13 PM, the Administrator agreed Resident #74's Level I PASRR did not reflect the resident's psychiatric diagnoses or medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 22445 Based on observation, interview, and record review, the facility failed to ensure medications were not left at the bedside of 1 (Resident #102) of 20 residents that resided in the Field of Dreams neighborhood, which was a locked behavioral unit. Findings included: A review of an Admission Record revealed the facility admitted Resident #102 on 07/10/2023. A review of a quarterly Minimum Data Set (MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes.), with an Assessment Reference Date (ARD) of 02/21/2024, revealed Resident #102 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. A review of Resident #102's April 2024 Medication Administration Record (MAR) revealed the resident was scheduled to receive the following medications during the 9:00 AM medication pass on 04/22/2024: - allopurinol oral tablet 300 milligrams (mg), one tablet one time a day for prevention of calcium-containing kidney stones; - aspirin delayed release 81 mg tablet, one tablet one time day to prevent a heart attack; - cholecalciferol (vitamin D3) 5000 units, give 5000 units by mouth one time a day for supplement; - duloxetine hydrocholoride (HCl) delayed release 30 mg, one capsule by mouth one time a day for neuropathic pain; - FiberCon oral tablet 625 mg, give two tablets by mouth one time a day for loose stools; - furosemide 40 mg, one tablet by mouth one time a day related to hypertensive heart and chronic kidney disease; - loratadine 10 mg, one tablet by mouth one time a day for inflammation of the nose due to allergy; -potassium chloride extended release 20 milliequivalents (meq), one tablet by mouth one time a day related to hypertensive heart and chronic kidney disease; - valsartan oral tablet 160 mg, one tablet by mouth one time a day for hypertension; - apple cider vinegar gummy, one gummy by mouth two times a day with meals; - magnesium oxide oral tablet 400 mg, two tablets by mouth two times a day for low magnesium; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- pregabalin oral capsule 100 mg, one capsule by mouth two times a day for nerve pain; and - guaifenesin oral tablet 400 mg, one tablet three times a day for congestion. An observation on 04/22/2024 at 10:15 AM revealed a cup of medication at Resident #102's bedside. A gummy was still inside the medication cup, and the resident had removed one pink pill and two white pills and placed them on their over-the-bed table. Resident #102 said they had already taken a few of the medications and indicated the nurse left the medications in their room, because the nurse trusted the resident would take them. Resident #102 said it was not unusual for the nurse to leave the medications in their room. During an interview on 04/22/2024 at 10:30 AM, Registered Nurse (RN) C revealed the danger of leaving medications in a resident's room could be the resident may spill them, not take the medications, or may choke on the medications. RN C further stated there were residents who wandered that resided on the unit, and they could wander into the room and take the medications. During an interview on 04/25/2024 at 9:45 AM, the Chief Nursing Officer (CNO) revealed they expected nurses to observe residents taking their medications and did not expect the nurses to leave medications in residents' rooms. The CNO stated it was important for the nurse to stay in the room while the resident took the medications, because leaving the room had the potential to harm any wandering residents that might take the medications. During an interview on 04/25/2024 at 2:25 PM, the Administrator revealed the consequences of leaving medications at a resident's bedside included the resident not taking the medications or other residents could take the medications.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37683 Based on observations, interviews, and facility policy review, the facility failed to ensure staff stored foods for residents in a sanitary manner. Specifically, staff failed to label and date resident foods brought in by visitors, clear the nourishment refrigerators of spoiled foods, and maintain the temperature logs for the nourishment refrigerators. This had the potential to affect 153 residents who resided in 6 neighborhoods (Wind Song Way, Field of Dreams, [NAME] Way, Tranquility Road, Sunshine Gardens, and Safe Harbor) of 10 total neighborhoods in the facility. Findings included: Review of a facility policy titled, Use and Storage of Food Brought in by Family or Visitors, last modified on 10/21/2019, revealed, Policy: It is the right of the residents of this facility to have food brought in by family or other visitors. However, the food must be handled in a way to ensure the safety of the resident. The policy specified, 2. All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. b. The prepared food must be consumed by the resident within 3 days. c. If not consumed within 3 days, food will be thrown away by facility staff. Review of a facility policy titled, Cleaning Responsibilities for Nursing Personnel, last modified on 01/31/2020, revealed that Nurses are responsible for cleaning the medication room and refrigerators. On 04/25/2024 at 3:11 PM the Director of Support Services stated there was no facility policy addressing nourishment refrigerators. On 04/25/2024 at 11:10 AM, observation of the nourishment refrigerator for the Windsong Way neighborhood revealed the April 2024 Dietary Refrigerator Temperature log specified, Refrigerator temperatures range: Between 32 and 40 degrees Fahrenheit Refrigerator Temperature MUST be recorded daily. The April 2024 log was missing documentation of temperature checks for 14 days (04/01/2024, 04/02/2024, 04/07/2024, 04/08/2024, 04/09/2024, 04/13/2024, 04/14/2024, 04/18/2024, 04/19/2024, 04/20/2024, 04/21/2024, 04/22/2024, 04/23/2024, and 04/24/2024). The refrigerator contained three plastic sealable food-storage containers labeled for a resident, but there were no dates indicating when they were first stored in the refrigerator. The refrigerator also contained a container of leftover food labeled for another resident, but there was no date to indicate when the item was first stored in the refrigerator. An open container of butter spread that was not labeled with the date it was opened was also observed in the nourishment refrigerator. During an interview on 04/25/2024 at 11:10 AM, Nursing Assistant (NA) J and NA K both revealed that the food items that had been opened should have been dated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/25/2024 at 11:49 AM, observation of the nourishment refrigerator for the Field of Dreams neighborhood revealed the April 2024 Dietary Refrigerator Temperature log was missing documentation of temperature checks for eight days (04/02/2024, 04/08/2024, 04/09/2024, 04/13/2024, 04/14/2024, 04/18/2024, 04/20/2024, and 04/24/2024). During an interview on 04/25/2024 at 11:50 AM, Registered Nurse (RN) L said the dietary department maintained the nourishment refrigerators. On 04/25/2024 at 1:42 PM, observation of the nourishment refrigerator for the [NAME] Way neighborhood revealed the April 2024 Dietary Refrigerator Temperature log was missing documentation of temperature checks for eight days (04/01/2024, 04/07/2024, 04/08/2024, 04/09/2024, 04/18/2024, 04/19/2024, 04/23/2024, and 04/24/2024). On 04/25/2024 at 1:45 PM, observation of the nourishment refrigerator for the Tranquility Road neighborhood revealed the April 2024 Dietary Refrigerator Temperature log was missing documentation of temperature checks for 10 days (04/02/2024, 04/07/2024, 04/08/2024, 04/09/2024, 04/11/2024, 04/12/2024, 04/18/2024, 04/20/2024, 04/23/2024, and 04/24/2024). The refrigerator also contained a bottle of cranberry juice that was opened and undated. On 04/25/2024 at 1:45 PM, observation of the nourishment refrigerator for the Sunshine Gardens neighborhood revealed food items labeled for residents but undated, including a pizza box containing leftover pizza, a package of sliced cheese, and a package of cracker cut cheese. The packages of sliced cheese and cracker cut cheese had a greenish-grey discoloration. During an interview on 04/25/2024 at 1:45 PM, Health Unit Assistant ([NAME]) M for Sunshine Gardens confirmed the sliced cheese and cracker cut cheese were moldy and promptly discarded them. [NAME] M also confirmed the pizza box of leftover pizza was undated, but [NAME] M stated the pizza was received by the resident the day prior. On 04/25/2024 at 2:05 PM, observation of the nourishment refrigerator for the Safe Harbor neighborhood revealed an undated paper bag of food from a fast-food burger restaurant labeled for a resident. There was also an undated and unlabeled bag from a fast-food pizza restaurant and an opened, undated container of salad dressing that was frozen solid due to being stored too close to the freezer section of the refrigerator. During an interview on 04/25/2024 at 2:05 PM, [NAME] N for Safe Harbor revealed they did not know where the bag from the fast-food pizza restaurant came from, and it would have to be discarded. [NAME] N said the undated bag from the fast-food burger restaurant belonged to one of the residents, and [NAME] N then went to ask the resident when it was received so it could be dated. During an interview on 04/25/2024 at 3:11 PM, the Director of Support Services (DSS), including Food Services, revealed food service staff managed the nourishment refrigerators and that it was their responsibility to record the temperatures on the logs. The DSS said any foods brought into residents should be labeled with the resident's name and the date it was received and should be discarded after three days. The DSS also confirmed that it was facility expectation that undated food items be discarded from the nourishment refrigerators, and any spoilt food, including the moldy cheese, should also be discarded. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas County Health Center	4102 Woolworth Avenue Omaha, NE 68105

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 04/26/2024 at 11:01 AM, the Administrator revealed dietary staff were responsible for checking the temperatures of the nourishment refrigerators daily, and nursing staff were responsible for the day-to-day maintenance of the nourishment refrigerators, including cleaning the refrigerators of spoilt or outdated items and labeling and dating residents' foods. During an interview on 04/26/2024 at 11:10 AM, the Assistant Director of Nursing (ADON) revealed the facility expectation was that food brought in from visitors be labeled and dated, that the refrigerator temperatures be logged daily, and for the refrigerators to be checked daily and any outdated, undated, or spoilt food items discarded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 22445 Based on observations, interviews, review of medical records, and facility policy review, the facility failed to ensure staff performed hand hygiene and did not touch medications with their bare hands when administering medication for 1 (Resident #160) of 3 residents observed during medication pass. Findings included: A review of a facility policy titled, Hand Hygiene, last modified on 07/14/2023, revealed, 2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. A review of the attached Hand Hygiene Table revealed staff should perform hand hygiene with Either Soap and Water or Alcohol Based Hand Rub (ABHR is preferred) Between resident contacts and Before preparing or handling medications. A review of an Admission Record revealed the facility admitted Resident #160 on 03/21/2018. According to the Admission Record, the resident had a medical history that included diagnoses of vascular dementia without behavioral disturbance, psychotic disturbance, mood disturbance, or anxiety; type two diabetes mellitus; hypertensive heart disease without heart failure; unspecified mood disorder; and vitamin D deficiency. A review of Resident #160's quarterly Minimum Data Set (MDS is part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes.), with an Assessment Reference Date (ARD) of 03/11/2024, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 1, which indicated the resident had severe cognitive impairment. An observation was made on 04/24/2024 at 8:30 AM of Registered Nurse (RN) A preparing to give medications to Resident #160. The nurse had just completed medication pass with another resident in the dining area and returned to the medication cart. RN A was not observed to use hand sanitizer or wash their hands prior to beginning medication pass for Resident #160. While preparing Resident #160's medications, RN A touched two of them with their bare hands when removing the medications from the container and placing them into a medication cup. During an interview on 04/24/2024 at 8:34 AM, RN A revealed normally they would not put medications in their hand and touch the pills, but the surveyor's observation had interrupted their normal routine. During an interview on 04/24/2024 at 8:35 AM, RN B revealed they expected staff to wash their hands between residents and expected a nurse not to place medications into their bare hand prior to giving the medication to a resident, and added it was an infection control issue. An interview was held with the Chief Nursing Officer (CNO) on 04/25/2024 at 9:36 AM. The CNO stated she expected medications not to be touched with bare hands due to infection control purposes. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285019	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/26/2024
NAME OF PROVIDER OR SUPPLIER Douglas County Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 Woolworth Avenue Omaha, NE 68105	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was held with Staff Development Instructor (SDI) OO on 04/25/2024 at 12:24 PM. SDI OO stated that during nurse education the facility's nurses were trained not to touch medications with their bare hands. SDI OO stated the nurses were to open the medication container and drop the medication into the cup. SDI OO stated the issue with touching medications with bare hands would be an infection control issue with cross contamination from the nurse's hands to the resident's medications.