STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285054	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure reference: 12-006.04(F)(i)(5) Based on observation, interview, and record review, the facility failed ensure provider was notified of weight loss for 1 [Resident 9] of 5 residents sampled for nutrition. Findings are: A. A review of Resident 9's admission record revealed Resident 9 was admitted to the facility on [DATE] with diagnoses of cerebrovascular disease [stroke] and dysphagia [difficulty swallowing]. A review of Resident 9's Care Plan revealed a focus area initiated 2/10/17 and revised 12/3/24 of compromised nutritional status with weight loss noted 12/1/24 and the following interventions: -Assess oral intake dated 2/10/17 -Offer the resident a bedtime snack dated 2/10/17 -Provided dietary supplements as ordered dated 5/28/19 -Provide/serve the resident's nutritional diet as ordered. Monitor and record intake with every meal dated 2/10/17 and revised 12/18/19. -Weight will be obtained as ordered by medical doctor dated 2/10/17 Observations on 12/3/24 at 12:06 PM and 12:55 PM revealed Resident 9 eating lunch including chicken, potatoes, cornbread, and pears. Resident 9 was observed to eat the chicken, half the potatoes, the corn bread, and the pears. A review of Resident 9's weights in the electronic medical record revealed a weight of 136.2 lbs. [pounds] on 10/30/24 and a weight of 121.8 lbs. on 11/27/24 which reflects a weight loss of 14.4 lbs. or 10.57% in 1 month. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Dietary Note dated 11/15/24 revealed Resident 9 weighed 136.2 lbs. on 10/3/24 and weighed 123 lbs. on 11/13/24 which was a 9% weight loss in 30 days. Dietary note identified Resident 9's nutritional needs as 1397-1650 calories, 1650, cc fluid, and 55 grams protein. The plan included recommendations of increasing med pass supplement from once per day to 3 times per day and notifying medical doctor of weight loss. A review of Resident 9's Progress Notes did not reveal documentation of Resident 9's provider being notified of Resident 9's weight loss. In an interview on 12/5/24 at 2:20 PM, Assistant Director of Nursing A confirmed there was not evidence of Resident 9's provider being notified of the weight loss.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure reference: 175 NAC 12-006.19 and 175 NAC 12-007.04(C) Based on observations, interviews, and record reviews, the facility failed to ensure temperatures were maintained on the 200 hallway which has the potential to affect 16 residents residing on the 100 hallway, the handrails on the 300/400 unit were in good repair which has the potential to affect 37 residents residing in the 300 and 400 hallway, the door to the smoking room was in good repair which has the potential to affect 16 residents who smoke at the facility, and a guard was in place on the baseboard heater in room [ROOM NUMBER] which has the potential to affect 2 resident residing in room [ROOM NUMBER]. The facility had a total census 117 residents. Findings are: A. Observations on 12/2/24 at 3:24 PM revealed a temperature of 69 F [Fahrenheit] on the thermometer located in the 200 hallway. Observations on 12/3/24 between 11:40 AM and 3:46 PM revealed the following temperatures on the thermometer located in the 200 hallway: -12/3/24 11:40 AM 63 F -12/3/24 12:24 PM 64 F -12/3/24 12:56 PM 65 F -12/3/24 2:40 PM 67 F -12/3/24 3:46 PM 68 F Observations on 12/4/24 between 5:38 AM-12:33 PM revealed the following temperatures on the thermometer located in the 200 hallway: -12/4/24 5:38 AM 68 F -12/4/24 7:10 AM 68 F -12/4/24 10:10 AM 69 F -12/4/24 12:33 AM 70 F Observations on 12/5/24 between 6:05 AM-7:01 AM revealed the following temperatures on the thermometer located in the 200 hallway: -12/5/24 6:05 AM 63 F (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12/5/24 7:01 AM 63 F In an interview on 12/5/24 between 9:13-9:25 AM, Resident 60 reported being cold. Observations on 12/5/24 between 9:13-9:25 AM revealed Resident 6 was wearing a shawl made from a blanket and temperature on thermometer in room showed 62.8 F. In an interview on 12/5/24 at 7:10 AM, the Administrator and the Maintenance Director confirmed that the temperature on thermometer located in the 200 hallway was 63 F and the thermometer was set at 90 F. The furnace for this area was replaced in 2/2024. The Administrator and the Maintenance Director confirmed that the furnace unit is not working as it should and the heating air conditioning company can not determine what is wrong. In an interview on 12/5/24 at 7:45 AM, the Maintenance Director reported the service call on 11/29/24 was for the furnace on the 200 hallway A review of invoice from Heating and Air Conditioning company dated 11/29/24 revealed the work request for newer unit set at 85 degrees with it only 68 degrees in the building. Description of Repair on the invoice identified the following: -unit running with all operations normal but with low air flow -followed all ductwork in the attic found no issues -checked electrics and blower motor drive ok -11/30/24 attended to same call and found same issues as previous B. Observations on 12/5/24 at 11:17 AM revealed the finish on the handrails was worn off on the hall from the dining room and down the 300/400 hallways. In an interview on 12/5/24 at 11:17 AM, the Maintenance Director confirmed that the finish on the handrails was worn off in the 300/400 hallways and confirmed that a work order had not yet been made. C. Observations on 12/5/24 between 10:06-10:35 AM revealed the door to the smoking area was dented and daylight could be seen through the door frame. In an interview on 12/5/24 between 10:06-10:35 AM, the Maintenance Director confirmed the exit door to the smoking area needed to be replaced and the replacement had not been approved. D. Observations on 12/5/24 at 10:20 AM revealed the guard on the baseboard heater in room [ROOM NUMBER] was missing. In an interview on 12/5/24 at 10:20 AM, the Maintenance Director confirmed the guard over the baseboard heater was missing.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Based on record review and interview, the facility failed to ensure resident's conditions was evaluated for readmission following hospitalization for 1 [Resident 119] of 3 residents sampled for hospitalization . The facility had a total census of 117 residents. Findings are: A review of Resident 119 Admission Record revealed Resident 119 was admitted to the facility on [DATE] with Malignant Carcinoid tumor of the Bronchus and Lung [cancer], Secondary Malignant Neoplasm of Left Adrenal Gland [a cancerous tumor that has spread], and Secondary Malignant Neoplasm of Right Adrenal Gland. A review of Resident 119 Progress Notes revealed the following: -9/3/24 at 2:56 PM Facility staff and Resident 119's family met via zoom to touch regarding resident behaviors and discharge plan. Team discussed resident being sent to the hospital with family for admission to psychiatric care unit to address medications and behaviors. Hospice was agreeable to plan. -9/3/24 at 5:54 PM Resident was discharged from facility to home with family. All medications and belongings were sent with family. A review of Resident 119's Notice of Resident Transfer or discharge date d 9/3/24 revealed Resident 119 was being discharged to the hospital related to transfer/discharge being necessary for the resident's welfare and the resident's need cannot be met by the facility and the safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident i.e. resident is aggressive and destructive. The Transfer/Discharge Notice included contact information for the Department of Health and Human Services Legal Services, the long-term care Ombudsman, Department of Health and Human Services Division of Developmental Disabilities, and Adult Protective Services. A review of Resident 119's hospice discharge order dated 9/3/24 revealed Resident 119 was being discharged from facility to the hospital. In an interview on 12/5/24 at 4:03 PM, the Administrator reported that the discharge order dated 9/3/24 was the only discharge notice that Resident 119 received and that all admissions are reviewed by a centralized intake. A review of email chain dated 9/9/24 revealed email at 6 AM referral for Resident 119 with a response email at 8:06 AM that denied placement at facility due to property destruction while at facility. A review of facility policy titled Transfer and discharge date d 4/1/24 revealed the following Under Emergency Transfers/Discharges section: (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-i. The resident will be permitted to return to the facility upon discharge from the acute care setting. -j. In a situation where the facility initiates discharge while the resident is in the hospital following emergency transfer, the facility will have evidence that the resident's status at the time the resident seeks to return to the facility meets one of the specified exemptions (see#2, a-d of this policy for list of exemptions). -k. In situations where the facility has decided to discharge the resident while the resident is still hospitalized , the facility will send a notice of discharge to the resident and resident representative before the discharge to the resident and resident representative before the discharge and must also send a copy of the discharge notice to a representative of the Office of the State Long-Term Care Ombudsman. Notice to the Ombudsman will occur at the same time the notice of discharge is provided to the resident and resident representative, even though, at the time of initial emergency transfer, sending a copy of the transfer notice to the Ombudsman only needed to occur as soon as practicable. -l. The resident has the right to return to the facility pending an appeal of any facility-initiated discharge unless the return would endanger the health or safety of the resident or other individuals in the facility. The facility will document the danger that the failure to transfer or discharge would pose. A review of facility policy titled Transfer and discharge date d 4/1/24 revealed the following under Policy Explanation and Compliance Guidelines: -2. Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: a. The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. b. the Transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility. c. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. d. The health of individuals in the facility would otherwise be endangered. e. The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for his or her stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. f. The facility ceases to operate.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614 Licensure Reference Number 175 NAC 12.006.09 Based on observation, interview and record review, the facility failed to ensure an order for daily weights was followed for 1 (Resident 34), failed to ensure a providers' order was clarified for 1 (Resident 12) and failed to ensure an order to discontinue medication was transcribed for 1 (Resident 7). The total sample size was 24. The facility had a census of 117. Findings are: A. A record review of Resident 24's Minimum Data Set (MDS - a standardized assessment tool used to evaluate the health of residents in nursing homes that are certified by Medicare or Medicaid) dated 9/2/24 revealed Resident 34 had a Brief Interview for Mental Status (BIMS - a screening tool used to assess a person's cognitive functioning) of 15, indicating the resident was cognitively intact. A record review of Resident 34's Electronic Health Record (EHR) revealed Resident 34 has the following diagnoses: -Acute on chronic diastolic (congestive) heart failure (a condition in which the heart doesn't pump blood as well as it should) -Unspecified chronic kidney disease. (a condition in which the kidneys don't filter waste as well as they should. Record review of a practitioners order dated 2/17/2024 revealed the following order: Daily weight - use Hoyer (a mechanical device that provides safe transfers for people with limited mobility) scale for accuracy. Notify provider if 2 lb (lb-a unit of weight) weight gain in one day or 5 lb gain in one week to be completed one time a day related to Acute Kidney failure (a condition in which the kidneys suddenly can't filter waste from the blood) and acute on chronic diastolic (congestive) heart failure (a condition in which the heart doesn't pump blood as well as it should). A record review of Resident 34's weights between 6/1/24 and 12/5/24 revealed Resident 34 did not have a weight recorded on the following dates: -May 2024, 1, 2, 3, 4, 5, 8, 9, 10, 12 and 18. -July 2024, 5, 14, 27. -August 2024, 4 and 23, -September 2024, 5, 8, 9, 16, 20 and 29. -October 2024, 1, 5, 6, 7, 8. 10, 13, 15, 24. -November 2024, 6 and 22. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/05/24 at 12:12 PM with Assistant Director of Nursing (ADON) L revealed ADON L had reviewed the weight record of Resident 34 and confirmed the resident did not have weights on the above-mentioned dates. An interview on 12/05/2024 at 12:27 PM with ADON L confirmed Resident 34 was to be weighed daily. ADON L further confirmed the providers order was not followed to obtain daily weights. B. A record review of Resident 12's Electronic Health Record (EHR) revealed the following diagnosis: -Type 2 diabetes mellitus without complications. (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A record review of Residents 12's MDS dated [DATE] revealed Resident 12 had a BIMS of 14, indicating the resident was cognitively intact. A record review of Resident 12's provider's order dated 12/1/2023 directed staff to Inject 1 application subcutaneously one time a day ,every Friday for infection control. An interview on 12/03/2024 at 2:35 PM with Resident 12 revealed the resident had a chest port (a device used to draw blood and give treatments, including intravenous fluids, blood transfusions, or drugs such as chemotherapy and antibiotics). The resident reported they were not receiving anything via the port and no one was accessing the port. An interview on 12/03/2024 at 3:45 PM with Registered nurse (RN) K reported they were not aware Resident 12 had a chest port. RN K further reported they had not accessed the port. An interview on 12/03/2024 at 4:30 PM with the Director of Nursing confirmed the order had been in place since 12/1/23 and had not been changed or discontinued. The DON confirmed they were unaware of the order until 12/3/24 when they were asked for clarification. The DON and the Nurse Consultant J confirmed the order should have been clarified. 04577 C. A review of Admission Record revealed Resident 7 was admitted to the facility on [DATE] with diagnoses of spinal stenosis [space inside the black bone is too small] and chronic pain syndrome [persistent pain]. A review of Resident 7's Progress Note dated 11/6/24 revealed an order to stop as needed acetaminophen and start acetaminophen 500 milligram (mg) 2 tabs (1000 mg) orally three times per day. A review of Resident 7's 11/2024 MAR [Medication Administration Record], 12/2024 MAR, and order summary revealed order for as needed acetaminophen had not been discontinued. In an interview on 12/5/24 at 9:46 AM, the Director of Nursing confirmed that Resident 7's as needed acetaminophen had not been discontinued.

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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** 47733 Licensure Reference Number 175 NAC 12-006.09(H)(iii)(1) Based on record review, observation and interview; the facility staff failed to implement interventions to prevent pressure ulcer development for 1 Resident (Resident 5) of 7 residents sampled. The facility identified a census of 117. Findings are: Record review of Resident 5's Comprehensive Care Plan (CCP) dated 12/04/2024 revealed an admitted [DATE] and had diagnoses as follows: - Cardiomegaly, - Presence of cardiac and vascular implant and graft, - Lack of coordination, - Muscle weakness, - Abnormalities of gait and mobility, - Nonrheumatic Mitral (Heart valve) Prolapse, - Iron Deficiency Anemia, - Congenital Malformations of Bladder and Urethra, - Reduced mobility. Further review of Resident 5's CCP dated 12/04/2024 revealed interventions to prevent skin integrity impairment related to decreased mobility was as follows: - Encourage good nutrition and hydration to promote healthier skin. Give prescribed supplements. - Encourage resident to allow staff to assist with repositioning off left buttock wound. May utilize positioning pillows as resident allows. - Follow facility protocols for treatment of injury. - Give supplement after meals per Medical Doctor (MD) order. - Identify/document potential causative factors and eliminate/resolve where possible. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Observe/document location, size, and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to MD. - Skin assessment upon admission/readmission and as needed (PRN). - Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. - Weekly skin inspection. - Wound care treatments as ordered. Additional review of Resident 5's CCP updated on 12/4/24 a Stage II (Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer) Pressure Ulcer (PU, refers to localized damage to the skin and/or underlying soft tissue usually over a bony prominence) to left buttock measuring 1.7 Centimeter (cm) x 0.7 cm x 0.1 cm. Record review of the Resident 5's Braden score (A risk assessment tool that predicts a patient's likelihood of developing pressure ulcers) on assessment dated [DATE] resulted in a score of 17 indicating mild risk of developing a pressure ulcer. Record review of the Minimum Data Set (MDS, a federally mandated assessment for the purpose of care planning) dated 9/30/24 revealed the facility staff assessed the following: -Had short-term and long-term memory deficit. -Required substantial to maximum assistance with personal hygiene. -Required substantial to maximum assistance with rolling side to side. -Required substantial to maximum assistance with repositioning. Record review of skin assessment dated [DATE] at 11:35 AM indicated no open areas. Record review revealed a progress note created by the facility's Registered Dietitian's (RD) dated 12/04/2024 revealed the RD identified Resident 5 had a new wound. Record review of Tissue Analytics (A software that the wound APRN documents their findings) notes from initial visit for this wound dated 12/05/2024 revealed the left buttock wound is new. An observation on 12/02/2024 at 8:35 AM revealed Resident 5 sleeping in the bed and was positioned on their back. Resident 5's back of head, shoulder's, coccyx, and heels were laying on the bed without protection. The foot and head of the bed were both elevated in a V like position causing Resident 5's buttock area to be pushed further into the mattress. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 12/02/2024 at 12:32 PM revealed Resident 5 sleeping in the bed. Resident 5 was positioned on their back. Resident 5's back of head, shoulder's, coccyx, and heels were laying on the bed without protection. The foot and head of the bed were both elevated approximately 30 degrees putting pressure to Resident 5's lower back, buttock, and heels. A continuous observation on 12/02/2024 at 12:41-1:04 PM revealed Resident 5 sleeping in a sitting position. The foot and the head of the bed were both elevated in a V like position causing Resident 5's buttock area to be pushed further into the mattress. An observation on 12/02/2024 at 2:30 PM revealed Resident 5 remained in the bed with the foot and head of the bed elevated in a V like position causing Resident 5's buttock area to be pushed further into the mattress. An observation on 12/02/2024 at 3:30 PM revealed Resident 5 remained in the bed with the foot and head of the bed elevated in a V like position causing Resident 5's buttock area to be pushed further into the mattress. An observation on 12/2/24 4:30 PM revealed Resident 5 remained in the bed with the foot and head of the bed elevated with Resident 5's back of head, shoulders, coccyx/buttocks, and heals were laying on the mattress. An observation on 12/03/2024 at 12:15 PM revealed Resident 5 remained positioned on their back. Resident 5's back of head, shoulder's, coccyx, and heels were laying on the mattress. The foot and head of the bed were both elevated in a V like position putting pressure to Resident 5's lower back, buttock, and heels. An observation on 12/03/24 12:26 PM revealed Resident 5 remained positioned on their back. Resident 5's back of head, shoulder's, coccyx, and heels were laying on the mattress. The foot and head of the bed were both elevated in a V like position putting pressure to Resident 5's lower back, buttock, and heels. An observation on 12/03/2024 at 12:50 PM revealed Resident 5 remained in the bed in the with heels, buttock, back and head against the mattress. An observation on 12/03/2024 at 1:28 PM revealed Resident 5 was laying with heels, buttock, back and head against the mattress. The foot and head of the bed were elevated approximately 30 degrees. An observation on 12/04/2024 at 9:40 AM revealed a wound on Resident 5's Left Ischium/ buttock (The left ischium forms the left lower and back region of the hip bone), the wound was open, raised with a beefy red wound bed, and was approximately 1.0 X 1.0. The Licensed Practical Nurse-E (LPN) placed barrier cream on the wound after Nursing Assistant's (NA) had provided personal care. An interview on 12/02/2024 at 1:10 PM with LPN-E revealed Resident 5 was sitting position in the bed with the foot and the head of the bed elevated. No protection for Resident 5's back of head, shoulder's, coccyx, or heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 12/04/24 Registered Nurse (RN)-L revealed Resident 5's heels were on the bed. RN-L confirmed that Resident 5's foot of the bed being raised was putting increased pressure to the Resident 5's heels. An interview on 12/04/2024 at 9:27 AM with LPN-E revealed Resident 5 did not previously have any open areas on the left ischium/ buttock. The LPN-E confirmed staff had not repositioned Resident 5. An interview on 12/04/24 9:40 AM confirmed LPN-E identified open-area to left ischium/ buttock and with the area and lack of repositioning this wound would be caused by pressure. An interview on 12/05/2024 at 11:32 AM with Advanced Practice Registered Nurse (APRN) wound nurse and discussed the causal factors and observations from the survey. The APRN reported with the additional observations and details provided, Resident 5's left ischium/ buttock wound would be considered pressure. APRN further confirmed no pressure prevention was observed. Record review of the facility's Pressure Injury Prevention Guidelines copyright dated 2023. Policy documented to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries. The facility is to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury. Policy Explanation and Compliance Guidelines: -Individual interventions will address specific factors identified in the resident's risk assessment, skin assessment, and the pressure injury assessment. -Interventions will be implemented in accordance with the physician orders, including the type of prevention device to be used. -Guidelines for prevention may be utilized in obtaining physician orders -Interventions will be documented in the care plan and communicated to all relevant staff. -Compliance with interventions will be documented in the medical record. -The effectiveness of interventions will be monitored through ongoing assessments of the resident and/or wound. -Preventive Skin Care -Nutrition/ hydration -Repositioning -Routine repositioning schedule: every two hours, using both side-lying and back positions. -Reposition when in bed, and out of bed. (continued on next page)

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	285054	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Avoid positioning the resident on bony prominences/turning surfaces with existing pressure injuries. Pressure Relieving Devices: -Pillows and wedges may be utilized to maintain proper repositioning. -Apply heel suspension devices according to the manufacture's instruction. -Provide alternative support surfaces as needed. Considerations for utilizing specialized support surfaces.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 21492 Licensure Reference Number 175 NAC 12-006.07 Based on record review and staff interviews; the facility Quality Assessment Performance Improvement (QAPI) program failed to identify ongoing issues relevant to F584 and F623 and implement plans of action to identify and correct the deficient practice. The facility QAPI program failed to ensure repeated deficiencies at F580, F684, F686, and F880 were corrected and the correction maintained on multiple surveys since 3-26-2024. The facility staff identified a census of 117. Findings are: Record review of the facility policy tilled Quality Assurance and Performance Improvement dated 8-31-2024 revealed the following information: -Policy: -It is the policy of this facility to develop, implement and maintain an effective, comprehensive, data-driven QAPI program the focuses on indicators of the outcomes of care and quality of life and address all the care and unique services the facility provided. 2. Governance and leadership: -b. Governing oversight responsibilities include,but are not limited to the following: -ii. Ensuring the program is ongoing, defined, implemented, maintained and addresses identified priorities. -v. Ensuring the program identifies and prioritizes problems and opportunities that reflect organizational processes, functions and services provided to residents based on performance indicator data and the resident, staff input, and other information. -e. QAPI training that outlines and informs staff of the elements of QAPI and goals of the facility will be mandatory for all staff. 3. Program Feedback, Data systems and monitoring- a. The facility maintain procedures for feedback, data collection system monitoring and including adverse event monitoring. b. The facility draws data from multiple sources including input from all staff, residents families and other as appropriate. Data sources my include, but not limited to: -xii. Staff, resident and family satisfaction surveys. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-xiii. Suggestions. During the the re-certification survey ending 12-05-2024, that included observations record reviews and interviews revealed new citations and repeated citations as following: -F584, The facility was cited related to temperatures in rooms, hand rails, and exit door. -F623, The facility was cited related to failing to evaluate a resident for readmission to the facility. -The repeated citation revealed the following: -F580. The facility staff failed to notify the practitioner of weight loss and failing to follow practitioners orders. -F684. The facility failed to discontinue an order, obtain ordered weights and obtain clarification of orders. -F686. The facility failed to implement interventions to prevent pressure ulcer development. -F880. The facility failed to ensure respiratory equipment was clean and stored to prevent potential contamination and fail to were PPE for residents on Enhanced Barrier Precautions (EBP, a set of infection control practices that use gowns and gloves during high-contact care activities to reduce the spread of multidrug-resistant organisms (MDROs). -F867. The facility failed to have an effective QAPI program as identified by current and repeated citations. On 12-05-2024 at 4:55 PM an interview was conducted with Nursing Assistant (NA) B. During the interview NA B reported not being aware of anything the QAPI committee was working on. On 12-05-2024 at 4:57 PM an interview was conducted with Licensed Practical Nurse (LPN) C. During the interview LPN C reported not being aware of what the QAPI committee was working on. On 12-05-2024 at 5:01 PM an interview was conducted with LPN D. During the interview LPN D reported they did not know what the QAPI committee was working on. ON 12-05-2024 at 5:05 PM an interview was conducted with LPN E. During the interview LPN E reported not knowing what the QAPI committee was working on. LPN E further reported having worked at the facility for a year. On 12-05-2024 at 5:08 PM an interview was conducted with NA F. During the interview NA F reported not being aware of what the QAPI committee was working on.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614 Licensure Reference Number 175 NAC 12.006.18 Based on observation, record review and interview, the facility failed to ensure a nurse performed hand hygiene, changed gloves, and wore a gown when providing care to 1 resident (Resident 115) of 1 resident who was on Enhanced Barrier Precautions (EBP - a set of infection control practices that use gowns and gloves during high-contact care activities to reduce the spread of multidrug-resistant organisms (MDROs). The total sample was 24. The facility census was 117. Findings are: A. A record review of Resident 115's Minimum Data Set, dated dated dated [DATE] (MDS - a standardized assessment tool used to evaluate the health of residents in nursing homes that are certified by Medicare or Medicaid) dated 9/2/24 revealed Resident 115 had a Brief Interview for Mental Status (BIMS - a screening tool used to assess a person's cognitive functioning) of 4, indicating the resident had severe cognitive impairment. A record review of Resident 115's Electronic Health Record (EHR) revealed Resident had the following diagnoses: -Anorexia (an eating disorder that causes people to weigh less that is considered healthy for their age and height) -severe protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function) -adult failure to thrive (a syndrome in older adults characterized by unexplained weight loss, decreased appetite, poor nutrition, inactivity, and often accompanied by depression, cognitive decline and functional impairments). An observation on 12/2/2024 at 2:10 PM revealed Resident 115 had a staff member in their room as a 1-1 (a type of care that involves keeping a patient under constant observation to reduce the risk of harm) to prevent resident from removing their gastrostomy tube (G-tube - a method of delivering nutrition and fluids to the body when a person is unable to eat or drink safely by mouth). An observation on 12/2/2024 at 2:10 PM revealed a CDC (Centers for Disease Control and Prevention) Enhanced Barrier Precautions sign posted outside the resident room door. This stated everyone must clean their hands, including before entering and after leaving the room. It also stated providers and staff must also wear gown and gloves for high-contact resident care activities which includes feeding tube care and use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 12/04/2024 at 5:37 AM of Registered Nurse (RN) G who administered tube feeding (a method of delivering nutrition and fluids to the body when a person is unable to eat or drink safely by mouth) to Resident 115. RN G entered the residents room wearing gloves but no gown, placed the tube feeding bags on the bedside table and exited the room without removing the gloves or performing hand hygiene. RN G continued to wear the same soiled gloves while they collected 4 x 8 oz (ounce, a unit of measurement) of Osmolite 1.5 (a brand of tube feeding formula) and returned to the resident's room. RN G placed the formula on the bedside table and entered the resident bathroom, turned on the water and returned to the resident room. RN G was wearing the same soiled gloves. RN G poured the 4 containers of formula into one of the feeding bags, returned to the bathroom, filled a graduate container (a container with markings that indicate its volume) with water and returned to the resident room, where the RN then filled the 2nd bag with water. RN G hung the bags on a stand and returned to the bathroom to put more water in the graduate container before turning off the water. RN was wearing the same soiled gloves. RN G returned to the bedside with a 60 milliliter (ml - a unit of measurement) syringe and the graduate container. RN G used a stethoscope to check placement of the G tube. RN G placed the stethoscope on the residents' abdomen and pushed air through the syringe into the abdomen to ensure the G-tube remained in the stomach. RN G used the syringe to flush the tube with 30 ml of water wearing the same soiled gloves, RN G replaced the soiled dressing from around the g-tube with a clean one. RN G exit the resident room and went to the nurses' station, locate a connecting piece to facilitate the tube feeding and return to the residents' room wearing the same soiled gloves. RN G attached the tube feeding to the residents g tube and started the tube feeding. RN G gathered the trash and removed their gloves. RN G washed their hands after discarding the trash. An interview on 12/04/2024 at 5:57 AM with RN G confirmed RN G did not change their gloves, wash their hands, or don a gown prior to entering the residents' room at 5:37 AM, during the process of preparing and administering the tube feeding, when they changed the dressing around the G-tube or when checking the tube feeding for placement. RN G confirmed they had not changed their gloves or washed their hands when they left the room to collect supplies.