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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>285055 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>07/31/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Falls City Nursing and Rehabilitation Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>1720 Burton Drive<br>Falls City, NE 68355 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>(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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>                    | <p>Licensure Reference Number 175 NAC 12-006.11(E) Based on observation, interview, and record review, the facility failed to ensure the chemical low-temperature (temp) dish machine reached a minimum temp of 120 degrees Fahrenheit (F)(a temperature scale) during all wash and rinse cycles and failed to ensure spoiled vegetables from the garden were disposed of to prevent foodborne illness. This had the potential to affect 38 residents that consumed food from the kitchen. The total facility census was 39. Findings are:A.A record review of the facility's undated Dish Machine Temperature Log policy revealed the Dietary Manager (DM) would train dishwashing staff to monitor dish machine temperatures throughout the dishwashing process. Dishwashing staff would be trained to report any problem with the dish machine to the dietary supervisor as soon as they occur. A record review of the National Sanitation Foundation (NSF) Machine Operational Requirements sticker on the facility's dish machine revealed wash temperature was a minimum of 120 degrees F, and the minimum rinse temperature was 120 degrees F. A record review of the facility's Low Temperature Dish Machine Log dated July 2025 revealed the wash temp should have been greater than (&gt;) 120 degrees, and the rinse temperature should have been &gt; 75 degrees. An observation on 07/29/2025 at 11:38 AM revealed the facility's DM, took the Robot Coupe (a blender) supplies to dish room, loaded and ran the facility's chemical low-temp dish machine. The dish machine's temperature reached 88 degrees F during the wash cycle, 100 degrees F during the rinse cycle. The DM left the dishwashing area after starting the dish machine and returned to the prep area. The DM then returned to the dishwashing area, gathered the supplies, returned to the prep area and pureed the pasta dish with the washed Robot Coupe's supplies. An observation on 07/29/2025 at 12:29 PM revealed the facility's Regional Certified Dietary Manager (RCDM) revealed the RCDM ran a cookie sheet through the facility's dish machine. The wash temp reached 88 degrees F and the rinse temp reached 100 degrees F. The RCDM continued spraying off dishes while the dish machine ran its cycles. An observation on 07/29/2025 at 12:40 PM the RCDM removed the cookie sheet from the dish machine. The RCDM then loaded the dish machine with pots and kitchen utensils. The was temp reached 100 degrees F and the rinse temp reached 112 degrees F. In an interview on 07/29/2025 at 12:45 PM, Dietary Aide (DA)-F confirmed that the staff had to run the sanitizer 3-4 loads before it reaches 120 degrees F. In an interview on 07/31/2025 at 12:53 PM, the facility's Assistant Director of Nursing (ADON) confirmed 38 of the 39 residents in the facility consume food from the kitchen. In an interview on 07/29/2025 at 12:54 PM, the RCDM confirmed the dish machine did not reach 120 degrees F during the wash and rinse cycles until the last load the RCDM ran, and it should have. The contract company the facility's used to service the dish machine provided the Low Temperature Dish Machine Log sheet. In an interview on 07/30/2025 at 11:42 AM, a representative (Rep) from the facility's contracted dish machine service company confirmed the wash and rinse temperatures of the dish machine should have been a minimum of 120 degrees F to properly sanitize the dishes. B.A record review of the facility's Resident Consumption of Facility-Grown Produce policy dated 4/2025 revealed residents may consume the food from the garden provided all safety protocols are followed to mitigate (prevent) the risk of foodborne illness. An observation on 07/28/2025 at 9:15 AM revealed a box on the 3-compartment sink in the kitchen that contained 1 cucumber with a gray fuzzy coating on it and 2 soft tomatoes with brown holes in them and a gnat (a small flying insect) inside 1 of them that flew out. An observation on 07/28/2025 at 9:58 AM with the facility's Activities Director (AD), that was the active DM while the DM was out that morning, revealed a box on the 3-compartment sink in the kitchen that contained 1 cucumber with a gray fuzzy coating on it and 2 soft tomatoes with brown holes in them. In an interview on 07/28/2025 at 9:58 AM with the facility's AD, that was the active DM while the DM was out that morning, confirmed there was a box on the 3-compartment sink in the kitchen that contained 1 cucumber with a gray fuzzy coating on it and 2 soft tomatoes with brown holes in them, and should not have been. The AD confirmed they were from the facility's garden and threw the box of vegetables in the trash can.</p> |  |  |

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| <p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide or get specialized rehabilitative services as required for a resident.</p> <p>(continued on next page)</p>     |

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| <p>F 0825</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> LICENSURE REFERENCE NUMBER 175 NAC 12-006.13 Based on record reviews, observations, and interviews, the facility staff failed to implement speech therapy (ST, a type of therapy focused on improving or restoring a person's ability to swallow safely and effectively) orders for 1 (Resident 3) of 1 sampled resident. The facility staff identified a census of 40. Findings are:A record review of an admission Record printed on 07/29/2025 indicated Resident 3 was admitted to the facility on [DATE] with diagnoses of Parkinson's disease (a brain condition that causes problems with movement, mental health and other issues) and dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior). A record review of Resident 3's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 05/28/2025 revealed in Section K, Swallowing/Nutritional Status a check mark was placed under the question signs and symptoms of a swallowing disorder. The check mark was placed next to the option C. Coughing or choking during meals or when swallowing medications. The MDS also revealed Resident 3's Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 9, indicating the resident was moderately impaired. A record review of Resident 3's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed an intervention to monitor for signs and symptoms of dysphagia (difficulty in swallowing) related to the Parkinson's disease diagnosis. No information regarding intervention on how to respond to symptoms of dysphagia was noted. A record review of a fax communication sent to Resident 3's provider dated 12/27/2024 revealed a request for speech therapy (ST) to eval/tx (evaluate and treat) with a handwritten response of yes please. The order was signed by MDS-licensed practical nurse (LPN, a nurse who provide basic medical care under the supervision of a registered nurse or physician) on 01/02/2025. A record review of Resident 3's Medication Review Report dated 01/14/2025 revealed an order for ST to eval/tx with an order date of 1/02/2025 signed by the provider on 01/14/2025.A record review of Resident 3's Speech Therapy Discharge Summary dated 03/21/2024 to 4/10/2024 revealed a discharge summary completed date of 4/29/2024. The facility was unable to provide more recent documentation related to speech therapy. An observation of Resident 3 on 07/29/2025 at 7:55 AM revealed the resident coughing and choking after drinking a thin liquid from a coffee cup during breakfast. An observation of Resident 3 on 07/29/2025 at 8:18 AM revealed coughing heard from the resident while resident was sitting in the recliner. An observation of Resident 3 on 07/29/2025 at 11:26 AM revealed the resident drinking a clear, thin liquid from a straw after receiving medication in apple sauce. The resident began coughing and choking immediately after. An interview with Nursing Assistant (NA, a healthcare professional who provides basic care and support to the residents) NA-C on 07/30/2025 at 1:02 PM revealed that the NA had noticed Resident 3 coughing sometimes when drinking and stayed with Resident 3 until the resident was finished coughing and then reported to the nurse on duty. An interview on 07/30/2025 at 12:56 PM with Resident 3's family member reported that the resident did choke on both food and liquid. The family member felt it was related to the progression of the resident's Parkinson's disease. An interview with Occupational Therapist (OT, a healthcare professional who specializes in helping people improve their ability to perform everyday activities) OT-D on 07/30/2025 at 2:11 PM reported that the facility had not had an ST since December of 2024 and that some residents were going offsite for their therapy. An interview with Physical Therapist (PT, a healthcare professional who specializes in helping people improve physical movement) PT-E on 07/30/2025 at 2:11 PM reported that the facility has not had an ST since December of 2024 and that some residents were going offsite for their therapy. An interview on 07/31/2025 at 9:20 AM with Director of Nursing (DON), confirmed the last time the resident had received ST was in 2024.</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Licensure Reference Number 175 NAC 12-006.18(B) Based on observation, interview, and record review, the facility failed to ensure that 1 (Resident 4) of 2 sampled residents' oxygen concentrator filters were clean, the positive airway pressure (PAP) device (a machine used to treat sleep apnea) contained a filter, the tubing was replaced, and ensure that the nasal cannulas and PAP masks for 2 (Residents 4 and 13) of 2 sampled residents were clean and stored off the floor to prevent the potential for cross contamination. The facility census was 39. Findings are:A.</p> <p>A record review of the facility's undated "Respiratory Equipment Policy" revealed PAP masks, tubing, and filters must be cleaned and disinfected per manufacturer instructions and replaced as needed (at least every 3-6 months or sooner if damaged or contaminated).</p> <p>A record review of the undated "ResMed AirSense 10 Users Guide" revealed the air filter should be replaced at least every 6 months and more often if needed. <a href="https://document.resmed.com/documents/products/machine/airsense-series/user-guide/airsense-10-device-with-humidifier_user-guide_amer_eng.pdf">https://document.resmed.com/documents/products/machine/airsense-series/user-guide/airsense-10-device-with-humidifier_user-guide_amer_eng.pdf</a></p> <p>A record review of the undated "Mirage FX NASAL MASK User Guide" revealed that the mask and headgear should only be gently handwashed. Daily or after each use, disassemble the mask components according to the disassembly instructions. Thoroughly clean the separated mask components, excluding the headgear, by gently rubbing them in warm water (approximately 86°F/30°C) using mild soap and rinse all components well with drinking-quality water and allow them to air dry out of direct sunlight. Once completely dry, reassemble the mask components following the reassembly instructions. <a href="https://document.resmed.com/documents/products/mask/mirage-series/user-guide/mirage-fx_user-guide_amer_por.pdf">https://document.resmed.com/documents/products/mask/mirage-series/user-guide/mirage-fx_user-guide_amer_por.pdf</a></p> <p>A record review of Resident 4's "Order Summary Report" dated 07/29/2025 revealed the resident had an order for PAP set at 7 centimeters of water pressure. The order stated to clean the CPAP mask and equipment with soapy water daily.</p> <p>An observation on 07/28/2025 at 11:14 AM revealed that Resident 4's ResMed AirSense 10 PAP device had no filter in place, the PAP mask (Mirage FX) was not cleaned, and the tubing was discolored, bent, and visibly worn.</p> <p>An observation on 07/29/2025 at 3:30 PM revealed that Resident 4's ResMed AirSense 10 PAP machine was on the resident's bedside table. The filter housing was opened, and no filter was found to be installed in the designated compartment. No replacement or spare filters were available in the immediate vicinity. The PAP tubing was cloudy, coated with visible interior film, and displayed signs of wear including kinking and reduced flexibility. The PAP mask appeared to have accumulated residue, indicating it had not been cleaned.</p> <p>In an interview on 07/29/2025 at 4:49 PM, Registered Nurse (RN)-A, confirmed that Resident 4's PAP should have had a filter, the tubing was visibly worn and coated, and the mask had not been cleaned and should have been.</p> <p>B.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>A record review of the facility's undated "Oxygen Policy" revealed that tubing must be kept off the floor and equipment must be cleaned regularly. Oxygen cannulas or masks should be changed when soiled or dirty.</p> <p>A record review of Resident 4's "Order Summary Report" dated 07/29/2025 revealed the resident had an order for Oxygen at 2 liters continuously via nasal cannula every shift for shortness of breath.</p> <p>An observation on 07/28/2025 at 11:14 AM revealed that Resident 4's nasal cannula was connected to the oxygen tank on the rear of the wheelchair, with nasal prongs resting directly on the floor. The oxygen concentrator had a dense buildup of dark gray, fuzzy sediment on both side filters.</p> <p>An observation on 07/29/2025 at 3:30 PM revealed that Resident 4's nasal cannula was connected to an oxygen tank secured to the back of the resident's wheelchair. The tubing was draped across the frame with the prongs resting on the floor. No device was observed to elevate or contain the tubing. An oxygen concentrator was positioned on the floor. Both air intake filters were covered in a dense, gray, fuzzy layer, spanning the full filter surface and obscuring the mesh beneath.</p> <p>In an interview on 07/29/2025 at 4:49 PM, RN-A, confirmed that Resident 4's nasal cannula should not have been on the floor and the oxygen concentrator filters were gray, fuzzy, and should have been clean. RN-A confirmed that these conditions were not acceptable and should not have occurred.</p> <p>C.</p> <p>A record review of Resident 13's admission record revealed Resident 13 was admitted to the facility on [DATE].</p> <p>A record review of Resident 13's diagnosis revealed gender had Sleep Apnea (Breathing stops and starts while sleeping), Lung nodules (small mass in lungs), Emphysema (a condition in which the air sacs of the lungs are damaged and enlarged causing breathlessness.) Chronic Obstructive Pulmonary Disease (COPD) a pulmonary disease that is characterized by chronic typically irreversible airway obstruction resulting in a slowed rate of exhalation.</p> <p>A record review of Resident 13's Care plan dated 03/28/2021 revealed to give oxygen therapy as ordered by the physician. It also stated to clean the PAP (positive airway pressure device used to treat respiratory conditions) mask and equipment with soapy water daily and rinse well. When clean hang the tubing to dry.</p> <p>A record review of Resident 13's Care Plan dated 03/28/2021 revealed gender had altered respiratory status with difficulty breathing related to Sleep Apnea and COPD.</p> <p>A record review of Resident 13's physician order dated 4/21/2025 revealed that the staff are to ensure the oxygen tubing is on Resident 13 properly related to it slipping off Resident 13's face every 2 hours for monitoring.</p> <p>An observation on 07/28/2025 at 2:18 PM revealed that Resident 13 had the PAP device face mask lying on the bedside dresser with area on the inside of mask having brown and black flecks.</p> <p>(continued on next page)</p> |  |  |

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| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>An observation on 07/29/2025 at 7:45 AM revealed that Resident 13's PAP device face mask was sitting on top of used clothing protector and had scattered brown and black flecks on the inside of mask.</p> <p>An observation on 7/30/25 at 2:30 PM revealed that Resident 13's PAP device face mask lying in gender's recliner chair.</p> <p>An observation on 07/31/2025 at 8:01 AM of Resident 13's room revealed PAP device mask was lying on top of the gender's hat which was on top of the bedside table. There were scattered black and brown flecks on the inside surface of the mask.</p> <p>An observation on 07/31/2025 at 10:10 AM of Resident 13's room revealed that the PAP mask was lying on top of a blanket in gender's recliner chair. The PAP face mask had flecks of brown and black on the inside of the mask. The nasal cannula portion of the resident's oxygen tubing was on the floor.</p> <p>An observation on 07/31/2025 at 10:10 AM of Resident 13's room revealed the nasal cannula of the oxygen tubing was lying on the floor.</p> <p>An interview on 07/28/2025 at 2:05 PM revealed Resident 13 stated gender had a respiratory infection a two weeks ago and that is why gender was on oxygen and used a PAP machine at night.</p> <p>An interview on 07/30/2025 at 10:06 AM with Resident 13 revealed gender had oxygen tubing on with physician setting for amount of oxygen delivered. Resident 13 stated that the oxygen keeps them from having difficulty breathing.</p> <p>An interview on 07/31/2025 at 10:19 AM with Medication Aide B (MA-B) revealed that the PAP device facemask and tubing in Resident 13's room was sitting on top of a blanket in recliner chair and that Resident 13's oxygen tubing had the nasal cannula lying on the floor. MA- B clarified that the PAP device mask should be cleaned and put on top of a paper towel after each use and that there were a few specks of brown and black on the inside of the mask. MA-B clarified that when the oxygen tubing was off the resident, it was supposed to be put in the bag that holds it on the oxygen concentrator.</p> <p>An interview on 07/31/2025 at 11:12 AM with the Director of Nursing (DON) revealed that when the PAP device was taken off in the morning it should have been cleaned with soap and water and put on a paper towel and tubing hung up to air dry. The DON stated that if the oxygen tubing was removed by Resident 13 it was supposed to be put in the bag on the concentrator machine.</p> |  |  |