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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285074 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 02/13/2025 |
| NAME OF PROVIDER OR SUPPLIER David Place | | STREET ADDRESS, CITY, STATE, ZIP CODE 260 South 10th Street David City, NE 68632 | |
| 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) | | |
| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47312</p> <p>Licensure Reference Number 175 NAC 12-006.09B</p> <p>Based on record review and interview; the facility failed to ensure the Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) reflected hypoglycemic (medication used to help reduce the amount of sugar present in the blood) medication use for two (Resident 23 and Resident 28) of 15 sampled residents. The facility census was 57.</p> <p>Findings are:</p> <p>A review of the CMS's (Centers for Medicare and Medicaid [NAME]) RAI (Resident Assessment Instrument) Version 3.0 Manual, dated October 2024, revealed the following regarding hypoglycemic (including insulin) medication use: Check if a hypoglycemic medication was taken by the resident at any time during the 7-day observation period (or since admission/entry or reentry if less than 7 days.)</p> <p>In an interview on 2/13/25 at 8:38 AM, the Assistant Director of Nursing/MDS Coordinator (ADON/MDS) confirmed that the facility follows the RAI Manual when completing an MDS.</p> <p>A.</p> <p>A review of Resident 23's January 2025 Medication Administration Record (MAR) revealed that [gender] received Metformin (a hypoglycemic medication) 1000 milligrams (mg) two times a day (BID) between 1/7/25 and 1/13/25.</p> <p>A review of Resident 23's MDS, dated [DATE], revealed that hypoglycemic medication use was not checked as taken by [gender] at any time during the 7-day observation period.</p> <p>In an interview on 2/13/25 at 8:38 AM the ADON/MDS Coordinator confirmed that Resident 23 had received a hypoglycemic medication during the 7-day observation period, that it was not check on the MDS and that it should have been.</p> <p>B.</p> <p>(continued on next page)</p> | | |

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 |
| FORM CMS-2567 (02/99) Previous Versions Obsolete | Event ID: | Facility ID: 285074 |
| | | If continuation sheet Page 1 of 7 |

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| <p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>A review of Resident 28's November 2024 MAR revealed that [gender] received the following hypoglycemic medications between 11/20/24-11/26/24: Humalog (insulin) 100unit/milliliters (ml) 12 units BID, Insulin Detemir 100unit/ml 15 units BID and Humalog 100unit/ml per sliding scale before meals.</p> <p>A review of Resident 28's MDS, dated [DATE], revealed that hypoglycemic medication use was not checked as taken by [gender] at any time during the 7-day observation period.</p> <p>In an interview on 2/13/25 at 8:49 AM the ADON/MDS Coordinator confirmed that Resident 28 had received hypoglycemic medication via insulin during the 7-day observation period, that it was not check on the MDS and that it should have been.</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>47312</p> <p>Licensure Reference Number 175 NAC 12-006.09D3(5)</p> <p>Based on record review and interview; the facility failed to follow the bowel protocol to prevent constipation for two (Resident 23 and 35) of two sampled residents. The facility census was 57.</p> <p>Findings are:</p> <p>A.</p> <p>Review of Resident 23's Bowel Movement Task, dated 1/13/25 to 2/11/25, revealed that [gender] did not have a bowel movement (BM) between the following dates: 1/15-1/18/25, 1/26-2/1/25 and 2/3-2/8/25.</p> <p>Review of Resident 23's Order Summary Report, dated 2/11/25, revealed the following medications used to promote bowel movements:</p> <p>-Milk of Magnesia Oral Suspension 400 milligram (mg)/5 milliliters (ml), give 30ml by mouth every 24 hours as needed,</p> <p>-Dulcolax Rectal Suppository 10mg insert 1 suppository rectally every 24 hours as needed.</p> <p>A review of Resident 23's January 2025 Medication Administration Record (MAR) revealed that [gender] received a Dulcolax suppository on 1/19/25, Milk of Magnesia on 1/23/25 and 1/31/25 and all were recorded that they were effective in promoting a BM.</p> <p>A review of Resident 23's electronic health record (EHR) revealed no documentation that a bowel assessment had been completed during the above listed dates or that [gender] medical provider had been notified due to not having a BM.</p> <p>In an interview on 2/13/25 at 10:57 AM, the Assistant Director of Nursing/Minimum Data Set (ADON/MDS) Coordinator revealed that the facility's bowel protocol is that a resident on day 1 of no BM is to receive fruit laxative or prune juice, on day 2 the Milk of Magnesia should be given, on day 3 the Dulcolax suppository should be given, and if the resident still has not had a BM by day 4 the resident's medical provider should be notified. The ADON/MDS Coordinator confirmed that the bowel protocol had not been followed for Resident 23 when [gender] had not had a BM 4 days (1/15-1/18/25), and 6 days (1/26-2/1/25 and 2/3-2/8/25) and that it should have been.</p> <p>45613</p> <p>B.</p> <p>During an interview on 2/10/25 at 2:02 PM Resident 35 stated I get constipated sometimes and my stomach hurts.</p> <p>(continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Review of Resident 35's bowel records for last 30 days revealed that from 1/22/25 - 1/26/25 the resident did not have a bowel movement (BM) and was 5 days with no BM.</p> <p>Review of Resident's 35's Quarterly Minimum Data Set -(MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 11/28/24 revealed</p> <ul style="list-style-type: none"> -resident was admitted to facility on 4/11/22 -BIMS score of 15 -primary diagnosis of post polio syndrome -resident is dependent for toileting transfer and for chair/bed to chair transfers <p>Review of Resident 35's Comprehensive Care Plan - (CCP- written instructions needed to provide effective and person centered care of the resident that meet professional standards of quality care) dated 7/21/22 the resident is dependent with wheel chair mobility, and dependent with full body lift for all transfers.</p> <p>Review of Resident 35's MAR revealed the resident did not receive any medications to prevent constipation in Dec, 2024, January, or Feb of 2025</p> <p>Review of Residents 35's Progress Notes dated from 1/01/25 through 2/1/25 revealed no bowel assessments or documentation of bowel medications given or MD notification regarding bowels.</p> <p>Review of facility's undated bowel protocol revealed:</p> <ul style="list-style-type: none"> -Day 1 = prune juice, prunes or fruit lax, -Day 2 = give MOM, -Day 3 = dulcolax suppository, -Day 4 = enema. <p>In an interview on 02/11/25 at 02:21 PM the ADON confirmed no progress note regarding bowel assessments and no bowel PRN's given in January and the MD should have been notified.</p> <p>In an interview on 02/13/25 at 11:16 AM the ADON confirmed that BM/constipation is not on the resident's careplan and that the fruit lax given on the 1st day of no BM is provided by the kitchen and is not charted in the residents MAR.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47312</p> <p>Licensure Reference Number 175 NAC 12-006.18(B)</p> <p>Licensure Reference Number 175 NAC 12-006.18(D)</p> <p>Based on observation, record review and interviews; the facility failed to ensure hand hygiene (HH-using an alcohol-based hand rub (ABHR) or washing hands with soap and water) was completed in a manner to prevent the potential for cross-contamination during peri-care (washing the genitals and anal area) for one (Resident 19) of one sampled residents for incontinence cares and failed to complete peri-care in a manner to prevent cross-contamination during wound care for one (Resident 15) of one sampled residents for wound care. The facility census was 57.</p> <p>Findings are:</p> <p>A review of the facility's Hand Hygiene competency, dated 12/2019, revealed the following:</p> <ul style="list-style-type: none"> -Hand hygiene using antimicrobial soap and water: 4. Lather and rub hands together for full 20 seconds, -When to wash hands: before each resident contact, after touching a resident or handling their belongings, after any contact with body fluids, after handling contaminated items (linens/garbage/briefs, etc), before and after gloving, -When can hand sanitizer be used: before/after direct contact with resident, after contact with resident's intact skin, after removing gloves or between changing gloves. <p>A review of the facilities Incontinent brief competency, dated 7/09, revealed the following:</p> <ul style="list-style-type: none"> -4. Obtain the appropriate perineal cleansing supplies and items needed, -5. Wash hands and put on gloves, -9. Perform proper peri-care, -10. Remove gloves, wash hands or sanitizer gel, replace gloves, -11. If resident is standing, position brief on their buttocks, -12. Gently extend the front of the brief between the resident's legs, -13. Position the front of the brief and fasten, -14. Remove gloves and wash hands. <p>A.</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 review of Resident 19's Minimum Data Set (MDS-a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care), dated 1/9/25, revealed that Resident 19 was dependent upon staff with toilet hygiene and was frequently incontinent of bladder.</p> <p>A review of Resident 19's electronic health record (EHR) revealed that Resident 19 had a Urinary Tract Infection (UTI-infection of any part of the urinary system) and was treated with an antibiotic from 1/9-1/13/25.</p> <p>In an observation on 2/13/25 from 12:39 PM to 12:45 PM of Resident 19 being assisted to the toilet, with the Assistant Director of Nursing/MDS Coordinator (ADON/MDS) present, by Nursing Assistant (NA)-A and NA-B revealed the following: upon entering Resident 19's room NA-B touched [gender] facial hair, did not complete HH and put gloves on. NA-A placed the gait belt around Resident 19's waist and assisted [gender] to a standing position and then pivoted to the toilet. NA-B pulled Resident 19's pants down and NA-A sat [gender] down on the toilet. NA-A removed the saturated brief and placed in the trash can with no gloves on. No HH was completed by NA-A. NA-A retrieved clean pants for [gender] while NA-B wiped the cushion in the wheelchair with a wet wipe, placed it in the trash can, grabbed a clean washcloth, dried the cushion off and placed the washcloth on the counter. When NA-A returned to the bathroom with clean pants, NA-B took the trash bag out of the trash can, grabbed a new trash bag from within the can, gave that to NA-A, placed the trash bag with the brief in it back in the trash can and then changed [gender] gloves. No HH was completed prior to putting new gloves on. NA-A placed the pants that Resident 19 had been wearing into the trash bag, assisted with putting [gender] clean pants on and did not complete HH. NA-A assisted Resident 19 to a standing position, while NA-B provided peri-cares to [gender]. NA-B obtained a new brief and applied the brief and pulled [gender] pants up, without changing gloves after providing peri-care. NA-A pivoted [gender] towards the wheelchair and sat [gender] down. NA-B removed [gender] gloves and washed hands with soap and water for seven seconds.</p> <p>In an interview on 2/13/25 at 12:47 PM, the ADON/MDS Coordinator confirmed that NA-A did not complete hand hygiene or wear gloves at any point while assisting Resident 19 and should have worn gloves and completed hand hygiene when gloves were changed. It also confirmed that NA-B did not complete hand hygiene after touching [gender] facial hair, change gloves or complete HH after wiping down and drying the wheelchair cushion, placed a dirty washcloth on the counter, change gloves and complete HH after providing peri-care and applying the new brief and washed hands with soap and water for only seven seconds.</p> <p>B.</p> <p>A review of Resident 15's admission record, dated 2/11/25, revealed a diagnosis of Pressure Ulcer of sacral region, stage 2 (PU-a pressure sore located on sacrum (the bony area at the base of the spine) where the skin has broken open, forming a shallow, open wound that extends into the deeper layers of the skin) with 12/18/24 listed as the date of onset.</p> <p>A review of Resident 15's MDS, dated [DATE], revealed that Resident 15 is always incontinent of bladder, dependent upon staff for toilet hygiene, had a Stage 2 pressure ulcer, and received PU care.</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 2/13/25 from 1:06 PM to 1:19 PM of peri-care and wound care for Resident 15, with the Infection Preventionist (IP) present, provided by NA-A and the Licensed Practical Nurse (LPN) revealed the following: NA-A assisted Resident 15 to [gender] left side while the LPN supported [gender] on [gender] left side. NA-A removed Resident 15's brief and tossed into the trash can on the other side of the bed next to the LPN. NA-A wiped Resident 15's buttocks using a different wet wipe, that had been placed on the bed, with each wipe. NA-A did not change [gender] gloves or complete HH. NA-A removed the dressing to [gender] sacral region, grabbed a new wet wipe and wiped from Resident 15's rectum across the open wound. This was done three times with a new wipe each time. NA-A then removed [gender] right glove and put on a new one without completing HH. NA-A placed the new brief against Resident 15's buttocks, removed [gender] gloves and did not complete HH. Resident 15 was then positioned onto [gender] right side. The LPN did change [gender] gloves after Resident 15 was repositioned to [gender] right side but did not complete HH. The LPN cleansed the wound with wound cleanser, changed [gender] gloves, completed HH, applied new gloves, applied the new treatment and dressing. Resident 15 was then assisted back onto [gender] back, the brief attached, covered up and [gender] call light was placed within [gender] reach. The LPN and NA-A then completed handwashing for the correct amount of time.</p> <p>In an interview on 2/13/25 at 1:23 PM, the IP, confirmed that NA-A and the LPN did not complete HH when their gloves were changed at the times mentioned above, NA-A tossed the dirty brief across the bed to the trash can and that NA-A wiped across Resident 15's wound after [gender] had wiped Resident 15's rectal area.</p> | | |