STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285076	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Palm at Regency Square	3501 Dakota Avenue South Sioux City, NE 68776

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 50683 Licensure Reference Number 175 NAC 12-006.19 Based on observations and interviews: the facility staff failed to maintain hallyway carpets in the center hallway, south hallway and the common area between 400 north and south hallways with the potential to effect 35 residents, failed to ensure2 (room [ROOM NUMBER], 402 and 405) ventilation covers were clean and failed to ensure a privacy curtain was in 1 residents room, room [ROOM NUMBER]. The facility staff identified a census of 49. Findings are: Observations on 6/24.2024 between 8:40 AM and 9:30 AM of the environmental tore revealed the following: - A shared toilet between rooms [ROOM NUMBERS] that lacked doors on both sides of the toilet. -Lingering strong urine smell in room [ROOM NUMBER]. -Bathroom ventilation's covers in rooms 310, 402, 405 covered with a gray fuzzy substance, resembling dust. -Stains (irregular shaped discolored blotches significantly darker than the surrounding carpet) down the Center, and South Hallways, and in the common area between 400 North and South Hallways). Carpet down the Center Hallway shows visible streaked linear lines. On 6/26.24 betwwen 1:45 PM and 2:15 PM of a environmental tour with the Maintenance Director (MD) revealed the following. -There was a lingering, strong urine smell in room [ROOM NUMBER]. MD reported that the urine smell was coming from the floor. -There was no privacy curtain of the shared toilet on side of room [ROOM NUMBER]. MD reported that there should be a privacy curtain on both sides of the shared toilet and that a privacy curtain was missing on the side of room [ROOM NUMBER]. (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
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was gray, fuzzy substance, resembling dust covering the bathroom vent in room [ROOM NUMBER] and room [ROOM NUMBER]. -Carpet flooring down the South Hallways showed visible stains of various, irregular shaped discolored blotches significantly darker than the surrounding carpet. -Carpet flooring down the Center Hallway was streaked with stained linear lines, resembling high volume traffic use. Large carpet stain irregularly shaped approximately 2 inches by 6 inches located three (3) feet inside Center Hallway near the Area 1 Nurse's Station (closest to the front entrance). A interview on 06/26/24 at 2:15 PM with Maintenance Director confirmed the above listed environmental concerns.

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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** 50683 Based on record review and interview, the facility failed to provide a written notice of transfer for 1 (Resident 252) and/or their representative upon transfer to the hospital and failed to notify a representative of the Office of the State Long-Term Care Ombudsman for 2 of 2 (Resident 1 and 252) residents sampled for hospitalization s. The facility census was 49. Findings are: A. Review of a Electronic Health Record (EHR,, is a digital version of a patient's paper chart)) for Resident 252 revealed Resident 252 had a fall on 05/25/24 and was transferred by ambulance to the hospital at 11:45 PM and returned to the facility on [DATE] at 2:31 AM. No bed hold notice was given to the resident or responsible party at time of transfer. On 05/26/24 at 12:30 PM Resident 252 was transferred by ambulance to the hospital. No bed hold notice was given to the resident or responsible party at time of transfer. An interview with the Social Services Director (SSD) on 06/26/24 at 10:50 AM confirmed that the facility did not give the notification of bed hold policy at time of transfer or as soon after to Resident 252 or their representative. An interview with the SSD on 06/26/24 at 10:50 AM confirmed that the facility did not send a copy of the notice of resident transfer out of the facility to a representative of the Office of the State Long-Term Care Ombudsman. Facility's Bed Hold Notice Upon Transfer Policy dated 8/1/23 revealed the following: At time of emergency transfer the resident and/or resident representative will be informed of bed hold option. The details of the bed hold will be provided in writing to the resident and/or resident representative as soon as possible. 49164 B. Record Review of Resident 1's EHR revealed an admitted [DATE]. Resident 1 had two hospitalization s one on 11-16-2023 and one on 12-09-2023. Record Review of Resident 1's progress notes dated 11-16-2023 revealed Resident 1 was transferred to hospital via Emergency Medical Services (EMS, also known as ambulance services or paramedic services, are emergency services that provide urgent pre-hospital treatment and stabilization for serious illness and injuries and transport to definitive care) and did not have indications the Ombudsman was notified. Record Review of Resident 1's progress notes dated 12-09-2024 revealed Resident 1 was transferred to the hospital via EMS. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 06-27-2024 at 10:25 AM with the Social Service Designee (SSD) confirmed that the facility had not notified the ombudsman of the transfers to the hospital on 11-16-2023 and 12-09-2023.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Based on record review and interview, the facility failed to provide a written notice of a bed hold for 2 (Resident 252 and 1) of 2 sampled residents. The facility census was 49. Findings are: A. A review of medical record for Resident 252 revealed Resident 252 had a fall on 05/25/24 and was transferred by ambulance to the hospital at 11:45 PM and returned to the facility on [DATE] at 02:31 AM. No bed hold notice was given to the resident or responsible party at time of transfer. On 05/26/24 at 12:30 PM Resident 252 was transferred by ambulance to the hospital. No bed hold notice was given to the resident or responsible party at time of transfer. Facility's Bed Hold Notice Upon Transfer Policy dated 8/1/23 revealed the following: At time of emergency transfer the resident and/or resident representative will be informed of bed hold option. The details of the bed hold will be provided in writing to the resident and/or resident representative soon as possible. An interview with Social Services Director (SSD) on 06/26/24 at 10:50 AM confirmed that the facility did not give timely notification of bed hold policy at time of transfer or discharge to Resident 252 or their representative on 05/25/24 at 11:45 PM or on 05/26/24 at 12:30 PM. 49164 B. Record Review of Resident 1's Electronic Health Record (EHR, is a digital version of a patient's paper chart)revealed Resident 1 was admitted on [DATE] and had been transferred to the hospital on 11-16-2023, 12-09-2023, 02-23-2024, and 05-19-2024. Record Review of Resident 1's medical record revealed there was no indications the facility provided a bed hold notice on 11-16-2023 and 12-09-2023. An interview conducted on 06-27-2024 at 10:25 AM with the SSD confirmed a bed hold notice was not issued to Resident 1 or Resident 1's representative for the hospital transfers on 11-16-2023 and 12-09-2023. Record Review of the facility policy Bed Hold Notice Upon Transfer dated 08-01-2023 revealed Policy: At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. At the time of emergency transfer the resident and/or the resident representative will be informed of bed hold option. The details of the bed hold will be provided in writing to the resident and/or resident representative as soon as possible.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Based on record review and interview, the facility failed to ensure a Preadmission Screening Resident Review (PASARR, a federally mandated screening process to ensure Nursing Home residents with mental illness and/or developmental disabilities receive the care and services they need in the most appropriate setting) was accurately completed for 1 (Resident 34) of 2 sampled residents. The facility sample was 49. Finding are: Record review of Resident 34's admission Minimum Date Set (MDS, a federally mandatory assessment tool used for care planning) dated 07/14/2023 was admitted to the facility on [DATE] with the diagnoses of Unspecified Dementia, Generalized Anxiety Disorder, Major Depressive Disorder, and Delusional Disorder. Record review of PASARR Level 1 screening form dated 07-12-2023 revealed Resident 34 was assessed as having no diagnosis or suspicion of Serious Mental Illness (SMI) or Intellectual Disability or Related Condition (ID/RC). Interview with the Social Services Director on 06/26/24 at 10:00 AM confirmed that the PASARR Level Screen for Resident 34 completed on 07/12/2023 was inaccurate. The SSD reported based on the Resident 34's Admission Diagnosis of Dementia, Major Depression, Delusional Disorder and Anxiety that a PASARR Level 2 screen should have been completed. A review of the facility's policy titled Resident's Assessment- Coordination with PASARR Program Date Implemented 8-1-23 and Date Reviewed/Revised 9-18-23 revealed the following: -Policy: -The facility coordinated assessment with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receive care and services in the most integrated stetting appropriate to their needs.

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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** 49164 Licensure Reference Number 175 NAC 12.006.09(H)(iii)(3) Based on observation, interview and record review;the facility staff failed to conduct skin evaluations and failed to provide wound treatments in the order time frames for 1(Resident 21) of 1 Residents. The facility census was 49. Findings are: A. Record review of Resident 21's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 05-21-2024 revealed Resident 21 admitted to the facility on [DATE] with diagnosis of morbid obesity, alcoholic cirrhosis of the liver, left above the knee amputation and was a carrier of Methicillin Resistant Staph Aureas (MRSA, is a staph bacteria that does not get better with the type of antibiotics that usually cure staph infections). The MDS also revealed Resident 21 had a Brief Interview of Mental Status (BIMS, an assessment that aids in detecting cognitive impairment. A score of 0-7 equals severe impairment, 8-12 indicates moderate impairment and 13-15 indicates cognitively intact) score of 15 indicating intact cognition. The MDS indicated Resident 21 required maximal assistance of staff to perform toileting hygiene and bathing, and was completely dependent on staff for toilet and shower transfers. Record review of Resident 21's Electronic Health Record (EHR, is a digital version of a patient's paper chart) revealed orders to perform a weekly skin assessment every Saturday on the evening shift and to document the assessment in Point Click Care (the name of the cloud based software used by the facility). Further review of Resident 21's EHR revealed there was not information in Resident EHR that indicating skin assessments were completed on 06-01-2024 and 06-22-2024 Record Review of Resident 21's weekly skin evaluations revealed a skin evaluation dated 06-08-2024 identifying a macerated (maceration is defined as the softening and breaking down of skin resulting from prolonged exposure to moisture) area to the left gluteal fold (the horizontal skin crease that forms below the buttocks, separating the upper thigh from the buttocks). Record Review of Resident 21's weekly skin evaluation dated 06-16-2024 revealed revealed Resident 21 had maceration to both the right and left gluteal folds. An observation on 06-26-2024 at 3:40 PM of Registered Nurse (RN) A performing wound care for Resident 21 revealed Resident 21 had skin maceration to skin under left breast, bilateral arm pits, the gluteal cleft (the groove between the buttocks) and in the folds of a left stump (the portion of the leg remaining after an amputation). An interview with the Director of Nursing (DON) conducted on 06-27-2024 at 12:00 PM confirmed that no other skin assessments were conducted after 06-16-2024 for Resident 21. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Record Review of Resident 21's Treatment Administration Record (TAR) dated 06-24-2024 revealed an order to Clean, dry and apply house powder to all folds twice a day at 8:00 AM and 8:00 PM for skin breakdown. In addition staff were to use Nystatin External Powder and to be apply to stump folds topically twice a day at 8:00 AM and 8:00 PM to prevent fungal infection and soreness. An observation on 6-26-2024 at 3:40 PM of RN A administering treatments to Resident 21's skin revealed RN A applied a house powder to all folds and Nystatin powder to Resident 21's stump. An interview was conducted on 06-26-2024 at 3:45 PM with RN A. During the interview RN A confirmed the ordered treatment for Resident 21's skin breakdown was followed. Record review of the facility's Wound Treatment Management policy dated 11-29-2023 revealed: -Policy: to promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. - Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician's orders, including the cleansing method, type of dressing, and frequency of dressing change. 2. In the absence of of treatment orders, the licensed nurse will notify physician to obtain treatment orders. 3. Dressing changes may be provided outside the frequency parameters in certain situations: -feces seeped underneath the dressing, the dressing had dislodged ,the dressing is soiled otherwise, or wet. 4. Dressings will be applied in accordance with manufacturer recommendations. 5. Treatment decisions will be based on: -etiology of the wound -characteristics of the wound -location of the wound -goals and preferences of the resident/representative 6. Guidelines for dressing selection may be utilized in obtaining physician orders 7. Treatments will be documented on the TAR or in the EHR. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound.

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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. 47733 Licensure Reference Number NAC 175 12-06.09(H)(iii)(2) Based on observation, interview and record review, the facility failed to implement a ordered treatment for 1 (Resident 37) of 3 sampled residents for wound care. The facility identified a census of 49. Findings are: Record review of Resident 37's (Treatment Administered Record) TAR for June 2024 revealed a treatment order for Resident 37's left heel ,was Skin Prep daily with an order date of 6/5/2024. An observation on 6/26/24 at 6:56 AM revealed (Registered Nurse) RN-A came into Resident 37's room to complete the residents wound care. RN-A had poured Betadine in a medication cup outside of the room and brought this medication cup into the room and reported the Betadine was for Resident 37's left heel ulcer. Further observation revealed RN-A using a cotton ball applied the Betidine to Resident 37's left heel. On 06/26/24 at 10:56 AM a interview was conducted with the (Director of Nursing) DON. During the interview the DON reported the treatment should have been performed as ordered. The DON confirmed the treatment order to Resident 37's left heel was skin prep. On 06/26/24 at 10:57 AM a Interview was conducted with RN-A. During the interview RN-A reported not being aware of what the current order for Resident 37's left heel.

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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. 49164 Licensure Reference Number 175 NAC 12.006.09(I) Based on observation, interview and record review the facility failed to implement interventions to prevent reoccurring falls for 1 of 4 residents (Resident 40). The facility census was 49. Findings are: Record Review of Resident 40's most recent Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 05-14-2024 revealed Resident 40 had a Brief Interview of Mental Status (BIMS, an assessment that aids in detecting cognitive impairment. A score of 0-7 equals severe impairment, 8-12 indicates moderate impairment and 13-15 indicates cognitively intact) score of 7 indicating severe impairment. The MDS also revealed Resident 40 had the diagnosis' of End Stage Renal Disease, Heart Failure, Diabetes Mellitus and Depression. According to the MDS Resident 40 needed partial assistance from staff for bed mobility, transfers, oral hygiene and upper body dressing and maximal assistance from staff for lower body dressing, bathing and personal hygiene. Record Review of Resident 40's Progress Notes dated 06-13-2024 revealed Resident 40 slid out of their wheelchair in the transportation van and the immediate intervention was to make sure Resident 40 was positioned correctly in wheelchair after dialysis. Record Review of Resident 40's Progress Notes dated 06-14-2024 revealed the interdisciplinary team had reviewed the fall on 06-13-2024 and determined the cause of the fall was related to Resident 40 sitting on a lift sling during transport to and from dialysis. The intervention was facility staff would put Resident 40 in the wheelchair with Dycem (Dycem(R) non-slip material is used to help stabilize objects, hold objects firmly in place, or to provide a better grip) on the cushion as well as Dycem between the sling and the resident on dialysis days or when the hoyer is used. An observation on 06-27-2024 at 10:40 AM of Nurse Aid (NA) C and Licensed Practical Nurse (LPN) B transferring Resident 40 into the wheelchair to go to dialysis revealed NA C obtained Resident 40's wheelchair and places it next to Resident 40 who was sitting in the recliner. Observation of the wheelchair revealed a cushion was present in the seat of the wheelchair. NA C places a hoyer lift sling in wheelchair on top of the wheelchair cushion There was no Dycem placed on the cushion or between the sling Resident 40 was transferred to the wheelchair with a sit to stand lift with the assistance of both NA C and LPN B. An interview with NA C on 06-27-2024 at 10:55 AM revealed NA C did not know the intervention of placing a Dycem in between the hoyer sling and the resident, and under the wheelchair cushion. An interview with LPN B on 6-27-2024 at 11:00 AM revealed LPN B did not know the intervention of placing a Dycem underneath the wheelchair cushion and in between the hoyer sling and the resident and LPN B confirmed the Dycem had not been applied. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing (DON) on 06-27-2024 at 12:00 PM confirmed the interventions were on Resident 40's Kardex (a nursing worksheet which includes a summary of patient information such as clinical follow-ups and daily care schedules) and the staff should have placed Dycem under the wheelchair cushion and between the hoyer sling and Resident 40.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614 Licensure Reference Number 175 NAC 12.006.09(J) Based on observation, interview and record review, the facility failed to follow physicians' orders for the administration of tube feeding for 1 (Resident 42) of 1. The facility identified a census of 49. Findings are: Record review of Resident 42's Minimum Data Set (MDS - a federally mandated assessment tool for Medicare and Medicaid residents) dated 2/22/2024 revealed Resident 42 had a Brief Interview for Mental Status (BIMS) score of a 8. According to the MDS [NAME] a score of 8 to 12 indicates a persons cognition is moderately impaired. Record review of Resident 42's MDS dated [DATE] revealed Resident 42 was receiving tube feeding. Record review of a practitioners order dated 6-21-2024 revealed Resident 42's practitioner order Novasource renal (a feeding formula) to be given at 65 milliliters (ml) per hour for 12 hours. An observation on 06/26/2024 at 7:1 5 AM of Resident 42 revealed Resident 42's tube feeding was being administered via gravity (a method to administer formula from the feeding bag into the feeding tube by the force of gravity) through a gravity set bag (a device that uses gravity to deliver a prescribed amount of formula feed to a patient through a feeding tube). The gravity set bag was dated 6/25/2024 and had the residents name on it with 50 milliliters (ml) of unidentified formula remained in the bag. The gravity set did not indicate what rate the formula was running at or how long it had been running. An interview with Licensed Practical Nurse B (LPN-B) on 06/26/2024 at 7:30 AM revealed LPN-B did not know what formula was being used or what rate it should be running at. LPN-B stated, it should be on the order. LPN-B did not know what amount of flush should be used when the tube feeding was finished or how to identify the amount of formula the resident received. LPN-B confirmed they did not know how to set up and administer tube feeding by gravity and further confirmed they could not find a physicians' order to administer the tube feeding by gravity. An interview with Registered Nurse-A (RN-A) on 06/26/2024 at 7:40 AM revealed RN-A was unable to find a physician's order to administer the tube feeding by gravity. RN-A confirmed they were unaware the tube feeding was being administered by gravity. An interview on 06/26/2024 at 9:15 AM with the Director of Nursing (DON) confirmed the DON was not aware that Resident 42's tube feeding was being administered by gravity. The DON confirmed a physicians' order was required prior to administering tube feeding via gravity.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614 Based on interview and record review, the facility failed to ensure targeted behaviors were identified, and that behavior monitoring for psychotropic medication was initiated for one resident (Resident 4) of 2 residents surveyed. The facility had a census of 49. Findings are: Record review of Resident 4's Minimum Data Sets (MDS - a federally mandated assessment tool for residents on Medicare and/or Medicaid) dated 5/28/2024 revealed Resident 4 had a Brief Interview of Mental Status (BIMS - a federally mandated tool to assess residents' cognitive function) of 15, indicating Resident 4 was cognitively intact. According to Resident 4's MDS dated [DATE] Resident 4 had the following diagnoses: Non-infective gastroenteritis and colitis, Type 2 Diabetes, Bipolar disorder, Malignant primary neoplasm, insomnia, Obesity, Muscle wasting and atrophy, anemia, Hypertension, cognitive communication deficit, repeated falls. Record review of a Order Summary Report (OSR) dated 6/25/2024 for Resident 4 revealed the practitioner order Lithium Carbonate (medication used to treat Bipolar Disorder) 300 milligrams to be given two times a day and Resperidone (an anti psychotic medication) 3 mg's daily. Further review of Resident 4's OSR dated 6/25/2024 revealed there were no indications of what specific behaviors staff were to monitor. Record review of Resident 4's medical record including progress notes, Care Plan, practitioners orders, Medication Administration Record (MAR) or Treatment Administration Record (MAR/TAR) for May 2024 and June 2024 did not have specific target behaviors to be monitored by staff. A record review of Resident 4's Care Plan dated 12/01/2023 revealed the following information: -Administer medications as ordered. Monitor/document for side effects and effectiveness. Risperdal, Lithium, Trazadone. Date initiated: 12/03/2023. -Monitor/record/report to MD PRN side effects and adverse reactions of psychoactive medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation's, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person as needed. Date initiated 12/02/2023. -Observe for changes in mentation, behavior, mood and affect. Date initiated: 12/02/2023. -Ongoing observation and assessment of mood changes and implementation of appropriate interventions according to necessity and Interdisciplinary Team (IDT) decision. Date Initiated: 12/02/2023. A record review of the facility's Use of Psychotropic Medication policy dated 08/01/2023 revealed the following information: (continued on next page)

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	285076	A. Building B. Wing	06/27/2024

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The Palm at Regency Square	3501 Dakota Avenue South Sioux City, NE 68776

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-2. The indications for initiating, withdrawing or withholding medications as well as the use of non-pharmacological approaches will be determined by a) assessing the residents underlying condition, current signs, symptoms, expressions, and preferences and goals for treatment -12: the effects of the psychotropic medications on a residents' physical mental and psychosocial well being will be evaluated on an ongoing basis, such as: d) In accordance with nurse assessments and medication monitoring parameters consistent with clinical standards of practice, manufacturers specifications and the residents comprehensive plan of care. -13. The residents' response to the medications including progress towards goals and presence/absence of adverse consequences, shall be documented in the residents' medical record. -14: Use of psychotropic medications in specific circumstances: b) Enduring conditions (i.e. non-acute, chronic or prolonged) i) the residents' symptoms and therapeutic goals shall be clearly and specifically identified and documented. On 6/26/2024 at 3:58 PM an interview was conducted with the Director of Nursing (DON). During the interview the DON confirmed there were not specific target behavior identified and being monitored for Resident 4.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 50683 Licensure Reference Number 175 NAC 12.006.11(E) Based on observations and interviews, the facility failed to a) ensure food products were disposed of prior to expiration dates, b) failed to implement and maintain the cleaning of food preparation equipment and surfaces to prevent the potential for food borne illness. This had the potential to affect 48 of 49 residents who eat from the kitchen. The facility census was 49. Finding are: During the initial kitchen tour on 06/24/24 from 9:05AM to 9:30 AM revealed the following: The walk-in refrigerator: -Gallon of 2% milk found in the walk-in refrigerator was open and only had 1/2 contents left was undated. In the walk-freezer: -Walk-in freezer had visible frost/ice buildup on the outside of the freezer door on the lower portion near the floor. The ice build-up covered the full length of the freezer door and approximately 8 inches high. -Unlabeled, undated bag of what appeared to be frozen egg patties or waffles observed inside walk-in freezer. In the reach-in refrigerator: -Three sandwiches wrapped in clear plastic wrap were not labeled or dated. -1 1/2 quart of unknown meat salad was not labeled or dated. -One tub of opened sour cream was not labeled or dated. The Dry Storage Area: -12 boxes sitting on the floor in the Dry Storage Area. -One open bag of Lemonade Drink Mix was tied shut with a twisty tie but was not dated. -One bag of Cocoa Powder was dated but was open (not securely closed). In the Dishwashing Area: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Steel metal grate hatch (approximately 3 feet by 3 feet) located in the dishwashing room was what resembles dust, and food debris build up around the edges. Duct tape covering the seam opening of the metal grate [NAME] and not intact with a large amount of what appears to be dust, food debris and grease buildup. Food service worker in the kitchen stated that they have tripped on this raveled duct tape several times. Grate on the floor was visibly dirty with rust buildup was not clean and was an uncleanable surface. -Oxidizes white/brown substance resembling hard water deposits, observed on the top of the dishwasher near both dishwasher drop down doors. In the Kitchen Preparation Area: -Numerous areas of what resembled dust, dirt, and grease build up observed in the seams of the kitchen linoleum flooring. -Small amount of oxidized white, dry, flakey substance noted on the outside, left-hand side of the ice machine lid. Observation of kitchen tour on 06/26/2024 at 08:05AM with the Certified Dietary Manger (CDM) revealed the following: -One tub of opened sour cream in the reach in refrigerator was not labeled or dated. -Large amount of dusty, sticky substance located on the outside of Cream of Tarter Seasoning plastic container. -Small amount of oxidized white, dry, flakey substance noted on the outside, left-hand side of the ice machine lid.--Open, undated bag of hot dogs loosely wrapped in clear plastic wrap observed in walk-in freezer. -1/4 container of low-fat cottage cheese in the walk-in refrigerator was undated. -1/2 container of opened sour cream in the reach in refrigerator was not labeled or dated. -Yellow, dried residue with 3-inch circular dark marks and scratches located on the kitchen linoleum flooring in the dry storage room where the wheels of a 6-metal storage rack rests. Dried food debris, resembling onion and cabbage leaves noted on the floor under the metal storage rack. -Unsealed linoleum patches located on kitchen flooring in front of the griddle stove, preparation table, and ovens not sealed. Previous sealant/caulking was broken revealing bottom floor surface; the area was not sealed and not a cleanable surface. A interview with CDM on 06/24/24 at 9:05 AM the CDM confirmed the above listed items from the kitchen tour on 06/26/2024 at 8:05 AM needed to be cleaned, repaired and/or corrected. Record Review of Nebraska Food Code reveals a regulation at 4-202.16 states that Nonfood-contact surfaces shall be free of unnessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record Review of Nebraska Food Code reveal a regulation at 3-305.11 States that Food shall be protected from contamination by storing the food 1) In a clean, dry location, 2) Where it is not exposed to splash, dust, or other contamination; and 3) At last 15 cm (6 inches) above the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interview and record review: the facility staff failed to ensure hand hygiene was performed after glove changes during peri care, catheter care, and wound care and failed to prevent potential cross contamination during these cares by placing the washcloths in the sink basins and on the bed covers without a barrier for 2 of 2 residents surveyed (Residents 1 and 21). The facility claimed a census of 49. Findings are: 49164 A. Record Review of Resident 1's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 05-25-2024 revealed Resident 1 admitted to the facility on [DATE] with the diagnosis of Heart Failure, Diabetes Mellitus Type 2, Schizophrenia, and Morbid Obesity. The MDS indicated Resident 1 had an indwelling catheter and required maximal assistance from staff to roll in bed, perform upper body dressing and personal hygiene and was dependent on staff to perform transfers, bathing, lower body dressing, and toileting hygiene. An observation on 06-26-2024 at 10:15 AM revealed Nurse Assistant (NA) D and NA E entered Resident 1's room to perform urinary catheter care and perineal care, wearing a gown and gloves. NA D placed a stack of washcloths in the bottom of the sink and turned on the water. After the washcloths were wet, NA D took the washcloths out of the sink and placed them onto Resident 1's bedside table without a barrier. Using one of the washcloths from the bedside table, NA D washed the right groin and the left groin, then using another washcloth from the bedside table, washed the urinary catheter tubing. Both NAs rolled Resident 1 to a side lying position, and NA D removed the incontinence brief that was soiled with feces. NA D removed soiled gloves and applied clean gloves without hand hygiene and used toilet paper to remove fecal matter from the resident's buttocks. After discarding the toilet paper, NA D used another washcloth from the bedside table and washed Resident 1's buttocks, then proceeded without changing gloves or performing hand hygiene to place a clean brief under the resident, apply barrier cream to the resident's skin, and place the catheter tubing into the securement device. NA D then removed gown and gloves and left the room without performing hand hygiene. NA E wearing the same soiled gloves throughout the procedure, covered Resident 1 with a sheet and went to the bathroom and returned with a paper towel, a graduate and alcohol wipes. NA E placed the paper towel on the floor and set the graduate on top of the towel and proceeded to empty the urinary catheter bag into the graduate. Once completed, NA E discarded urine into the toilet, removed gown and gloves and left the room without performing hand hygiene. An interview was conducted with NA D on 06-26-2025 at 10:35 AM confirmed the washcloths were placed in the bottom of the sink and hand hygiene should have been done after glove changes. An interview with NA E on 06-26-2024 at 10:45 AM confirmed NA E did not perform hand hygiene after removing gloves and should have. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Director of Nursing (DON) on 06-27-2024 at 12:02 PM confirmed hand hygiene should have been performed after glove changes, and using the bottom of the sink instead of a basin could cause cross contamination. Record Review of the facility policy Perineal Care (refers to the care of the external genitalia and the anal area) dated 11-28-2024 revealed it is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. The policy also revealed a basin of warm water was to be used to wet washcloths. B. Record review of Resident 21's MDS dated [DATE] revealed Resident 21 admitted to the facility on [DATE] with diagnosis of morbid obesity, alcoholic cirrhosis of the liver, left above the knee amputation and was a carrier of Methicillin Resistant Staph Aureas (MRSA, is a staph bacteria that does not get better with the type of antibiotics that usually cure staph infections). The MDS indicated Resident 21 required maximal assistance of staff to perform toileting hygiene and bathing and was completely dependent on staff for toilet and shower transfers. An observation on 6-26-2024 at 3:40 PM revealed NA E entered the room wearing a gown and gloves, to assist Registered Nurse (RN) A with personal care and wound care for Resident 21. NA E placed a stack of washcloths in the bottom of the sink and turned the water on. Once wet, the washcloths were hung on the inside of the sink basin. RN A entered Resident 21's room wearing a gown and gloves to provide a treatment to Resident 21. Resident 21 was lying on the bed, RN A lifts the resident's left breast, which was red and took a washcloth from inside the sink basin and washed the area and then applied powder to the area. RN A then removed soiled gloves and applied clean gloves without hand hygiene and then assisted NA E with positioning Resident 21 onto the right side. Resident 21's skin in the gluteal cleft was red with a yellow substance at the bottom of the cleft. RN A took one of the washcloths that were hanging in the sink basin and used it to wipe the buttocks and the gluteal cleft which began to bleed revealing an open slit in the skin. RN A applied powder to the area and placed a clean bottom sheet under Resident 21. After securing the bottom sheet to the bed, RN A rolled Resident 21 onto (gender) back, removed gloves and placed more washcloths in the bottom of the sink. RN A applied new gloves without performing hand hygiene and washed both armpits using washcloths out of the sink basin. After applying powder to the armpits, RN A removed the gloves and applied clean gloves and used a 4 by 4 inch gauze pad to cleanse the skin folds on Resident 21's left amputation site that was reddened with yellow drainage. After applying powder to the area, RN A removed gloves and gown and performed hand hygiene with soap and water for 30 seconds, then left the room. An interview conducted with RN A on 6-26-2024 at 4:45 PM confirmed that RN A did not perform hand hygiene in between glove changes and the placement of washcloths in the bottom of the sink could cause cross contamination. Record review of the facility policy Hand Hygiene dated 04-01-2024 revealed under Policy All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff in all locations within the facility. Under Policy Explanation and Compliance Guidelines 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Hand hygiene is indicated and will be performed under the conditions listed in, but not limited to, the attached hand hygiene table. 6. Additional considerations revealed the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to applying gloves and immediately after removing gloves. Under the attached Hand Hygiene Table situations are described that would require hand hygiene included -after handling contaminated objects -before and after removing personal protective equipment including gloves. -before and after handling clean or soiled dressings and linens -after handling items potentially contaminated with blood, body fluids, secretions or excretions -when during resident care, moving from a contaminated body site to a clean body site -after assistance with personal body functions (e.g.,elimination, hair grooming, smoking) An interview conducted with the Director of Nursing (DON) on 06-27-2024 at 12:02 PM confirmed that hand hygiene should have been done after glove changes and using the bottom of the sink instead of a basin could cause cross contamination.