

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Continental Springs, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 G Street South Sioux City, NE 68776	

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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>49164</p> <p>Licensure Reference Number 12.006.11(E)</p> <p>Based on observation and interview the facility failed to ensure the cleanliness of the shelf below the prep table and the stand-up mixer and failed to secure the floor tiles under the convection oven in a manner to prevent build up of dirt and debris. This had the ability to affect 49 of 52 residents who ate from the facility kitchen. The facility census was 52.</p> <p>The findings are:</p> <p>An observation on 10-28-2024 at 8:30 AM of the kitchen revealed food build up and debris on the bottom shelf of the prep table, and the stand-up mixer.</p> <p>An observation on 10-30-2024 at 10:00 AM of the kitchen revealed the floor tiles under the convection oven were no longer secured the underfloor and food debris were collecting underneath.</p> <p>An interview with the Kitchen Manager (KM) on 10-31-2024 at 9:30 AM confirmed the buildup and debris on the bottom shelf of the prep table and the stand-up mixer. Furthermore, the KM confirmed the flooring under the convection oven was coming loose from the underfloor and dirt and build up were collecting underneath.</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.

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: 285082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Continental Springs, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 G Street South Sioux City, NE 68776	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614</p> <p>Licensure Reference Number 175 NAC 12-006.18</p> <p>Based on observation, record review and interview; the facility staff failed to implement a water management plan to prevent potential illness such as Legionella(a bacteria) and failed to ensure a urinary catheter bag was secured to prevent potential contamination for 1 (Resident 12) of 3 residents. The facility had a census of 52.</p> <p>Findings are:</p> <p>A. Record review of a undated Policy and Procedure for the facility Water Management Program revealed the following information.</p> <p>-1. A water management team has been established to develop and implement the facility's water management program, including facility leadership the Infection Preventionist, maintenance employees, safety officers, risk and quality management staff, and Director of Nursing.</p> <p>a. Team members have been educated on the principles of an effective water management program, including how Legionella and other water-borne pathogens grow and spread. Education is consistent with each team members role.</p> <p>b. The water management team has access to water treatment professionals, environmental health specialists and state/local health officials.</p> <p>-2. The maintenance director maintains documentation that describes the facility's water system. A copy is kept in the water management binder.</p> <p>-3. A risk management assessment will be conducted by the water management team annually to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water systems. The risk assessment will consider the following elements:</p> <p>a. Premise plumbing. This includes water system components as described in the documentation of the facility's water system.</p> <p>b. Clinical equipment. This includes medical devices and other equipment utilized in the facility that can spread Legionella through aerosols or aspiration.</p> <p>c. At-risk population: This facility's entire population is at risk. High risk areas shall be identified through the risk assessment process. Supporting documentation of any areas or resident population that exhibit greater risk than the general population shall be kept in the water management program binder.</p> <p>-4. Data to be used for completing the risk assessment may include, but are not limited to</p> <p>a. Water system schematic description</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Continental Springs, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 G Street South Sioux City, NE 68776	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>b. Legionella environmental assessment</p> <p>c. Resident infection control surveillance data</p> <p>d. Environmental culture results</p> <p>e. rounding observation data</p> <p>f. water temp logs</p> <p>g. water quality reports from drinking water provider.</p> <p>h. community infection control surveillance data.</p> <p>-8. The water management team shall regularly verify that the water management program is being implemented as designed. Auditing assignments will reflect that individuals will now verify the program activity for which they are responsible.</p> <p>-9. The effectiveness of the water management program shall be evaluated no less than annually. Routine infection control surveillance data, water quality data and rounding data shall be utilized to validate the effectiveness.</p> <p>-12. The facility will conduct an annual review of the water management program as part of the annual review of the infection prevention and control program, and as needed, such as when any of the following events occur.</p> <p>-In the event of an update to the water management program, the water management team shall:</p> <p>-a. Update the water system/schematic/description, associated control points, control limits and</p> <p>-14: Documentation of all of the activities related to the water management program shall be maintained with the water management program binder for a minimum of 3 years.</p> <p>An interview on 10/31/2024 at 11:29 AM with the maintenance person K confirmed they could not locate a Water Management Plan or a schematic plan of the facility's water system and meant the facility did not have one.</p> <p>49164</p> <p>B. Record review of Resident 12's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 06-30-2024 revealed the facility staff assessed the following about the resident:</p> <p>-Brief Interview of Mental Status (BIMS) was scored as a 7. According to the MDS [NAME] a score of 0-7 indicates a person has a severe cognitive impairment.</p> <p>-Required extensive assistance with eating</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285082	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER Continental Springs, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 G Street South Sioux City, NE 68776	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Required total assistance with bed mobility, transfers, toileting, bathing, and dressing.</p> <p>An observation on 10-28-2024 at 2:27 PM of Resident 12 lying in bed with the urinary catheter bag laying face down on the fall mat next to Resident 12's bed.</p> <p>An observation on 10-30-2024 at 7:32 AM of Licensed Practical Nurse (LPN) A and LPN G performing catheter care for Resident 12 revealed the urinary catheter bag was hanging on the bed-frame. After performing catheter care, LPN A lowered the bed frame of the bed to the lowest position allowing the catheter bag to touch the floor.</p> <p>An interview on 10-30-2024 at 8:00 AM with LPN A confirmed the catheter bag was touching the floor.</p> <p>An observation after the interview with LPN A on 10-30-2024 at 8:00 AM revealed LPN A removed the catheter bag from the bed-frame and placed in on the fall mat next to Resident 12's bed.</p> <p>A follow up interview with LPN A confirmed that the fall mat on the floor was dirty and placing the catheter bag on the fall mat could cause cross contamination.</p> <p>An interview conducted on 10-31-2024 at 1:15 PM confirmed the catheter bag should not touch the floor, or the fall mat which is stored and used on the floor due to the potential for cross contamination.</p> <p>Record review of the facility's undated policy titled Catheter Care, Urinary revealed the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The policy directs staff to use aseptic technique when handling or manipulating the drainage system and to be sure the catheter tubing and drainage bag are kept off the floor.</p>