STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285087	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tiffany Square	3119 West Faidley Avenue Grand Island, NE 68803

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175 NAC 12-00.609 (H)(iii)(2) Based on observation, record review, and interview, the facility failed to provide wound care according to physcian orders for 2 residents, (Resident 2 and Resident 3) of 3 sampled residents, and the faccility failed to obtain physican orders for wound care for a pressure injury for 1 residnet (Resident 1) of 3 sampled residents. The facility census was 71. Findings are: Review of a facility policy titled Skin and Wound Management Standard dated 04/2019 revealed the treatment plan will be specific for each individual resident as directed by the physician. A. A review of an Admission Record revealed the facility admitted Resident 2 on 05/14/2024 with diagnoses of hepatic failure (when the liver can no longer function properly), congestive heart failure (when the heart cannot pump enough blood to the body), and dementia (which is a condition where thinking abilities are impaired enough to interfere with daily living). The Quarterly Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) with an Assessment Reference Date (ARD) of 12/06/2024 revealed Resident 2 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 11 indicating the resident was moderately impaired. The resident required supervision or touching assistance with eating and was dependent on staff assistance with bed mobility, toilet use, and transfers. The resident was coded to be at risk for pressure related skin conditions but did not have any present at time of assessment. Review of Resident 2's Care Plan dated 01/13/2024 revealed a problem of the resident having a pressure ulcer dated 12/30/2024. An intervention was listed with start date of 12/301/24 to administer treatments as ordered by physician and document. Review of Resident 2's Physician Orders dated 01/13/2024 revealed an order to cleans would with soap and water on coccyx then apply zinc oxide after cleansing twice daily. (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation completed on 01/13/2025 at 1:30 PM of wound care being completed by Licensed Practical Nurse B (LPN-B), LPN-B squirted a clear liquid from a vial labeled normal saline 0.9% onto Resident 2's wound located mid gluteal cleft. LPN-B the squirted some of the clear liquid onto folded 4X4 gauge and used the gauze to pat at the skin surrounding the wound and then over the top of the wound. In an interview completed on 01/13/2024 at 1:45 PM with LPN-B, LPN-B confirmed that the order for cleansing Resident 2's wound was to use soap and water not normal saline and gauze. In an interview completed on 01/14/2024 at 12:30 PM with the Director of Nursing (DON), the DON confirmed that LPN-B did not follow the physician orders for cleansing Resident 2's wound. B. Review of an Admission Record revealed the facility admitted Resident 3 on 05/10/2023 with diagnoses of hemiplegia and hemiparesis (which is the lack of ability to move extremities on one side of the body), type 2 diabetes (where the body has trouble controlling blood sugar and using it for energy), and chronic pulmonary disease (which is a lung disease that causes breathing problems). The Comprehensive MDS with and ARD of 11/15/2024 revealed Resident 3 had a BIMS score of 14 indicating the resident was cognitively intact. The resident was independent with eating and was dependent on staff assistance with bed mobility, toilet use, and transfers. The resident was coded to be at risk for and have an unhealed pressure injury. Review of Resident 3's Care Plan dated 01/13/2024 revealed a focus that resident 3 has a stage 3 pressure ulcer to the coccyx dated 11/11/2024. An intervention dated 11/11/2024 was listed to administer treatments as ordered by physician and document. Review of Resident 3's Physician Orders dated 01/14/2024 revealed an order to cleanse sacral wound with wound cleanser, pat dry with gauze. Apply thin layer of topical antibiotic, then a thin layer of viscous lidocaine to the wound bed. Apply skin prep to the perimeter of the wound and bordered foam once daily and as needed. In an observation completed on 01/14/2024 at 9:00 AM of wound care being completed by Registered Nurse A (RN-A), RN-A used a Q-Tip to apply topical antibiotic ointment to the skin directly surrounding the wound with visible depth located to Resident 3's gluteal cleft. RN-A then obtained another Q-Tip and applied viscous lidocaine over the same area. The RN did not apply the topical antibiotic ointment or the viscous lidocaine directly to the wound. The RN then applied skin prep to the skin surrounding where the topical antibiotic ointment and viscous lidocaine were applied and covered the area with a bordered foam dressing. In an interview on 01/14/2024 at 9:15 AM with RN-A, RN-A confirmed that they did not apply the topical antibiotic ointment and viscous lidocaine directly to the wound. In an interview on 01/14/2024 at 10:50 AM with Licensed Practical Nurse-G (LPN-G), LPN-G confirmed that the topical antibiotic ointment and viscous lidocaine was to be applied directly to the wound and the skin prep was to be applied to the skin surrounding the wound. LPN-G confirmed that RN-A did not complete the treatment to Resident 3 wound as ordered by the physician. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview completed on 01/14/2024 at 12:30 PM with the DON, the DON confirmed that RN-A did not follow the physician orders for cleansing Resident 3 wound. C. A review of an Admission Record revealed the facility admitted Resident 1 on 08/13/2024 with diagnoses of type 2 diabetes (where the body has trouble controlling blood sugar and using it for energy) and congestive heart failure (when the heart cannot pump enough blood to the body). The Quarterly MDS with an ARD of 11/29/2024 revealed Resident 1 had a BIMS score of 9 indicating the resident was cognitively impaired. The resident required supervision or touching assistance with eating and was dependent on staff assistance with bed mobility, toilet use, and transfers. The resident was coded to be at risk for pressure injury. Review of Resident 1's Care Plan dated 01/13/2025 revealed a focus of the resident having and being at risk for impairment to skin integrity. An intervention was listed to follow the facility skin and wound management standard and weekly and as needed skin monitoring by a professional nurse. Review of Resident 1's Progress Notes on 01/13/2025 documentation on 01/09/2024 that the resident returned to the facility with a pressure ulcer to the right buttock measuring 5.0 centimeters by 3.0 centimeters by 0.1 centimeters. Review of an After visit Summary dated 01/09/2025 revealed documentation that Resident 1 had a wound located to the right buttock. Review of an Visit Note Report dated 01/09/2025 revealed documentation by the Hospice nurse that Resident 1 had a pressure injury/ulcer located on the right buttock. Review of Resident 1's Physician Orders revealed no treatment order for Resident 1 pressure ulcer/injury located on the right buttock. In an interview on 01/14/2025 at 8:15 AM with RN-A, confirmed there was no treatment orders for the pressure injury/ulcer located on Resident 1's right buttock. In an interview on 01/14/2025 at 12:30 PM with the DON, the DON confirmed that Resident 1 was readmitted to the facility on [DATE] and documentation reflected that the resident had a pressure injury/ulcer to the right buttock. The DON confirmed no documentation present in the resident's physician orders for treatment of this area.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49382 Licensure Reference Number 175 NAC 12-006.18B Based on observation, record review, and interview, the facility failed to use Enhanced Barrier Precautions during direct care and to clean lifts between resident use for 1 resident (Resident 3) of 3 sampled residents, failed to provide wound cleansing in a manner to prevent cross contamination for 1 resident (Resident 2) of 3 sampled residents. The facility census was 71. Findings are: A. Review of a facility policy titled Policy for Enhanced Barrier Precautions (EBP) dated 04/05/2024 revealed that enhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs the use of gown and gloves during high contact resident cares such as transferring and changing briefs or assisting with toileting. Review of a facility policy titled Mechanical Lift and Transfer Standard dated 10/2024 revealed instruction for lift disinfection procedure to wipe all lift surfaces that come into direct contact with resident's skin with a approved disinfectant between each resident use. Heavy soiling, such as the foot plate, may require soap and water scrubbing prior to disinfecting. Review of an Admission Record revealed the facility admitted Resident 3 on 05/10/2023 with diagnoses of hemiplegia and hemiparesis (which is the lack of ability to move extremities on one side of the body), type 2 diabetes (where the body has trouble controlling blood sugar and using it for energy), and chronic pulmonary disease (which is a lung disease that causes breathing problems). The Comprehensive Minimum Data Set (MDS, a mandatory comprehensive assessment tool that measures the health status of nursing home residents and is used for care planning) with an Assessment Reference Date (ARD) of 11/15/2024 revealed Resident 3 had a Brief Interview for Mental Status (BIMS, a brief screening tool that aids in detecting cognitive impairment) score of 14 indicating the resident was cognitively intact. The resident was independent with eating and was dependent on staff assistance with bed mobility, toilet use, and transfers. Review of Resident 3's Care Plan dated 01/13/2024 revealed a focus that the resident had an activities of daily living self care performance deficit with an intervention listed to provide assistance of 2 staff and a full body lift to transfer the resident dated 05/10/2023. A focus of the resident being at risk for infection due to pressure injury/ulcer to coccyx with and intervention listed for enhanced barrier precautions for high contact activities dated 11/11/2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation completed on 01/13/2025 at 2:45 PM with Nurse Aide C (NA-C) and Nurse Aide E (NA-E) revealed they were assisting Resident 3 to transfer from a lying position in their bed up to a sitting position in their wheelchair using a full body lift. NA-C did not use or have a gown on while providing the direct care and assisting the resident with the transfer. NA-E did not use or have a gown on while providing the direct care and assisting the resident with the transfer. After using the lift to complete the transfer NA-E placed the lift over the resident's bed and proceeded to exit the resident's room. NA-C assisted to propel the resident from the room in their wheelchair and then returned to the resident room. The NA removed the lift from the room and placed the lift in the hallway outside of the resident's room. The NA then proceeded down the hall entering another resident's room. In an interview completed on 01/13/2025 at 3:10 PM with NA-C, NA-C confirmed that staff were to use enhanced barrier precautions when providing direct care for Resident 3. NA-C confirmed that they did not have or use a gown when assisting Resident 3 to transfer with the full body lift and should have. In an interview completed on 01/13/2025 at 3:10 PM with NA-E, NA-E confirmed that staff were to use enhanced barrier precautions when providing direct care for Resident 3, and staff were to cleanse the lift after each use. NA-E confirmed that they did not have or use a gown when assisting Resident 3 to transfer with the full body lift, and that they did not clean the lift after using it to assist Resident 3 and placing the lift in the hall for further use and should have. In an interview completed on 01/13/2024 at 4:10 PM with the Director of Nursing (DON), the DON confirmed that Resident 3 was on enhanced barrier precautions for all direct cares including transfers. The DON confirmed that NA-C and NA-E should have used a gown while assisting Resident 3 with the transfer. In an interview completed on 01/14/2024 at 11:10 PM with the DON, the DON confirmed that lifts are to be cleansed between each resident use including the foot plate of the sit to stand lift B. Review of a facility policy titled Skin and Wound Management Standard dated 04/2019 revealed dressing changes will be done using good infection control technique. A review of an Admission Record revealed the facility admitted Resident 2 on 05/14/2024 with diagnoses of hepatic failure (when the liver can no longer function properly), congestive heart failure (when the heart cannot pump enough blood to the body), and dementia (which is a condition where thinking abilities are impaired enough to interfere with daily living). The Quarterly MDS with an ARD of 12/06/2024 revealed Resident 2 had a BIMS score of 11 indicating the resident was moderately impaired. The resident required supervision or touching assistance with eating and was dependent on staff assistance with bed mobility, toilet use, and transfers. The resident was coded to be at risk for pressure related skin conditions but did not have any present at time of assessment. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Care Plan dated 01/13/2024 revealed a problem of the resident having a pressure ulcer dated 12/30/2024. An intervention dated 12/30/2024 was listed to administer treatments as ordered by physician and document. Review of Resident 2's Physician Orders dated 01/13/2024 revealed an order to cleans would with soap and water on coccyx then apply zinc oxide after cleansing twice daily. In an observation completed on 01/13/2025 at 1:30 PM of wound care being completed by Licensed Practical Nurse B (LPN-B), LPN-B squirted a clear liquid from a vial labeled normal saline 0.9% onto Resident 2 wound located mid gluteal cleft. LPN-B the squirted some of the clear liquid onto folded 4X4 gauge and used the gauze to pat at the skin surrounding the wound and then over the top of the wound. LPN-B applied a thick white cream to a gloved finger. The LPN then applied the cream to Resident 2 gluteal cleft starting at the resident's anus and spreading the cream up the cleft into the residents open wound located mid gluteal cleft. In an interview completed on 01/13/2025 at 1:45 PM with LPN-B, LPN-B confirmed that they did not cleanse the wound and apply the thick white cream in a manor to prevent cross contamination. In an interview completed on 01/14/2025 at 12:30 PM with the DON, the DON confirmed that they did not cleanse the wound and apply the thick white cream in a manor to prevent cross contamination.