STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285091	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indian Hills Manor	1720 North Spruce Ogallala, NE 69153

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49766 Licensure Reference 175 NAC 12-006.09D7 Based on observations, interviews, and record review; the facility failed to ensure call devices were within reach for 2 (Resident 14 and Resident 23) of 2 sampled residents. The facility identified a census of 34. The findings are: A record review of the facility policy Call Light Accessibility and Timely Response Policy and Procedure with a last revised date of March 2024 revealed staff will ensure the call light is within reach of residents and secured. A. A record review of Resident 14's annual Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), with an Assessment Reference Date (ARD) of 1/2/2024 revealed Resident 14 had a Brief Interview for Mental Status score of 5/15, which indicated Resident 14 had severe cognitive impairment. The MDS also revealed Resident 14 required max assistance for toileting, hygiene, and dressing. A record review of Resident 14's Care Plan, initiated on 9/12/2023, revealed Resident 14 was at risk for falls related to diagnoses of Dementia and Parkinson's with an intervention of having a reachable call light. An observation on 4/7/2024 at 2:08 PM revealed Resident 14 had been resting in bed. The call device had been hanging on the wall at the foot of the bed, not within Resident 14's reach. An observation on 4/8/2024 at 2:29 PM revealed Resident 14's call device had been hanging on the wall at the foot of the bed, not within Resident 14's reach. Resident 14 had been laying in bed while whimpering and crying out help me. B. (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: 285091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Indian Hills Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1720 North Spruce Ogallala, NE 69153	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 23's Care Plan, initiated on 9/26/2022, revealed Resident 23 had an activities of daily living (ADL) self-care deficit related to Dementia, impaired balance, and limited mobility with an intervention in place to encourage Resident 23 to use the call device for assistance. An observation on 4/7/2024 at 3:56 PM revealed Resident 23 had been resting in bed without a call device within reach or was not within the resident's viewable sight . An observation on 4/8/2024 at 2:30 PM revealed Resident 23 had been resting in bed without a call device within reach and was not within the resident's viewable sight. An interview on 4/9/2024 at 9:48 AM with Nurse Aide-L confirmed call devices should be in reach for all residents.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49263 Licensure Reference Number 175 NAC 12-006.06B Licensure Reference Number 175 NAC 12-006.05(7) Based on record review and interivews; the facility failed to resolve ongoing grievance concerns and failed to assure residents were able to voice concerns without retaliation by the staff. This had the potential to affect all residents. The facility census was 34. Findings Are: A. Record review of the facility policy Grievance/ Concern with a revision date of 3/2019 revealed the purpose of the policy was to ensure the residents had the right to voice grievances without discrimination or reprisal and without fear of discrimination or reprisal. The policy further revealed that grievances/concerns reported during resident and/or family council meetings were to be transferred to a grievance form and given to the Grievance Official or Administrator. In addition, all grievances/concerns were to be logged and completed by Social Services Director (SSD) or assigned to an appropriate designated person for investigation. A written report of the investigation and recommended action(s) were to be completed and returned to the SSD/Administrator within 72 hours. B. A record review of the Resident Council Agenda and Meeting Minutes dated 10/30/23 revealed the following concerns which were not resolved: -call lights were not being answered in a timely manner. -staff were not wiping off the bedside tables when room trays were picked up. -laundry was being left in the resident's rooms at night and was not put away. -staff were not knocking on doors before entering the resident's rooms. A new concern was identified regarding the resident's beds not getting made each day and the bed linens not getting replaced on the resident's bath days. A record review of the Resident Council Agenda and Meeting Minutes dated 11/28/23 revealed the following concerns remained unresolved: -resident beds were not being made each day. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-call lights were not answered in a timely manner. Residents at the meeting indicated call lights were not a problem during the day but remained a concern at night. -staff were not wiping off the bedside tables after picking up room trays. -laundry continued to be left in rooms and not put away. -staff continued entering the resident's room without first knocking. -beds were not stripped on bath days and clean linens provided. New concerns were identified regarding the provision of snacks and fresh ice water, resident clothing being placed in the wrong rooms and soiled plates not being removed from the resident's room when room trays were provided. In addition, the residents were not being notified when they were to get a bath each week. A record review of the Resident Council Agenda and Meeting Minutes dated 12/26/23 revealed the following concerns which were not resolved: -beds were still not being made. -staff continued to place the wrong clothing in the wrong closets. -soiled plates were not removed from the resident's rooms when they were provided a room tray. A new concern was identified regarding the nursing staff being unavailable as they were going out to smoke too many times and they also were not washing their hands after they smoked. A record review of the Resident Council Agenda and Meeting Minutes dated 1/30/24 revealed the following concerns which remained unresolved: -beds were not being made each day. -beds were not being stripped on bath days. -snacks and ice water were not being passed to all residents. -soiled plates were still not being picked up from the resident's room when they were given a room tray. A new Concern regarding staff failure to remove trash from the resident's rooms was identified. A record review of the Resident Council Agenda and Meeting Minutes dated 2/27/24 revealed the following unresolved concerns: -beds are not being made each day. -beds are not being stripped on bath days. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-snacks and ice water were still not provided for all residents. New concerns were identified regarding the condition of the facility front doors and the plaques for employee of the month were not being displayed. A record review of the Resident Council Agenda and Meeting Minutes dated 3/26/24 revealed the following concerns remained unresolved: -beds not getting made each day. -beds were not getting stripped on bath days. -snacks and ice water were still not provided for all residents. The following new concerns were identified: the staff were providing fresh ice water at night but instead of bringing into the resident's rooms, they were leaving on the rail outside of the room, the lights on the bird cage were not working, and the fitted sheets did not fit the beds correctly. C. An interview on 4/8/24 at 9:00 AM with Resident 26 revealed a concern regarding how the staff made their roommate/spouse's bed (Resident 25). Resident 25's call light was often left clipped to the fitted sheet underneath the blankets, and Resident 25 was unable to find. Resident 26 had reported this to the staff many times, but the staff continued to leave the call light where it was unavailable for Resident 25. In addition, at times the residents' bedding has not gotten changed out for several weeks even though it was to be changed weekly on the resident's bath day. Resident 25 had the same dried blood stain on linens for approximately 2 weeks. An observation on 4/8/24 at 9:02 AM revealed Resident 25's call light was clipped to the fitted sheet on the resident's bed. The sheet and blanket had been pulled up and were over the call light button and the call light was not readily accessible for Resident 25. An observation on 4/8/24 at 10:00 AM of Resident 25's bed revealed a dark red spot to the underside of the comforter, sheet, and soaker pad sheet. An interview on 4/9/24 at 2:25 PM with Resident 26 revealed at times, the staff would tell the Resident Council they were working on the identified concerns, but the concerns frequently remained unresolved. Resident 26 reported repeated concerns had been brought up during Resident Council regarding leaving the resident's ice water on the hallway rails outside of the resident's rooms, snacks not being passed in the evenings and mail not being delivered to the residents on Saturday due to staffing issues. Resident 26 expressed the following concerns: -staff had threatened to move Resident 25 out of the room shared with Resident 26 if Resident 26 complained too often. -Resident 25 was not assisted to lay down or repositioned in the recliner as staff indicated they didn't have enough staff and/or time. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-if staff would get too angry with Resident 26 for complaining, the staff will be mean to Resident 25. -staff will dress Resident 25 and then leave the room without offering the use of the bathroom. Resident 25 will turn on the call light, but no one will come as the staff are assisting in the dining room. Sometimes at night, it is 30-45 minutes after Resident 25 turns on the call light before assist is provided with toileting. -has noticed several staff go outside for their smoke breaks at the same time and when the call lights turn on, there is no one on the floor to answer them. D. An interview on 4/9/24 at 3:05 PM with the SSD confirmed the following: -mail was delivered to the facility on Saturdays and the nursing staff were to distribute it to the residents when delivered. -once the grievance forms were completed, they were to be given to the department responsible for addressing the issue. After the issues had been addressed, the responsible department would bring the form back to the SSD who would then take to the Administrator to be signed. the responsible department who addressed the issue would be the person responsible for talking to the resident to ensure they were satisfied with the results. If the person filing the grievance was not satisfied with the resolution, a different solution was to be found. -concerns brought forth during the Resident Council meetings were taken to the respective departments for resolution. -a response was not always received from the nursing department regarding concerns and the nursing department were not always notified if concerns remained. E. An interview on 4/9/24 at 3:55 PM with the Director of Nursing confirmed if mail was delivered to the facility on Saturdays, someone from nursing was to distribute it to the residents that same day.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09B. Based on record review and interview, the facility failed to accurately assess 1 (Resident 33) of 2 sampled resident's medication usage when completing their Admission Minimum Data Set (MDS, a federally mandated comprehensive assessment tool utilized to develop resident care plans). The facility census was 34. The findings are: A record review of Resident 33's Admission Record revealed the resident was admitted to the facility on [DATE] with diagnosis of Type 2 Diabetes Mellitus, (a long-term condition in which the body has trouble controlling blood sugar and using it for energy). A record review of Resident 33's Physician's Orders revealed an order for the nurses to monitor the resident for adverse effects from insulin and oral hypoglycemic medications each shift. Resident 33 also had medication orders for glipizide 10 milligrams (mg) twice a day (BID) and metformin 500mg BID, as well as an order for Victoza 1.8mg to be injected once a day. All of these medications were ordered for the resident's diagnosis of Type 2 Diabetes Mellitus, and they all had a start date of 2/12/24. An interview on 4/7/24 at 1:37 PM with Resident 33 confirmed the resident had been taking a medication called Victoza for about 5 to 6 years. The resident revealed that this medication was not an insulin but was an enzyme-prohibiting injectable drug that worked in the pancreas and helped to keep blood glucose levels stable. A record review of Resident 33's Admission MDS with a completion date of 2/24/24, revealed in Section C that the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, according to the RAI 3.0 User's Manual, this indicated the resident was cognitively intact. Section N of the MDS revealed documentation that the resident had one order for insulin and had received insulin injections 7 out of 7 days during the lookback period. Section N also indicated the resident had not received any hypoglycemic medications during the lookback period. A record review of Resident 33's February 2024 Medication Administration Record (MAR) revealed the resident did not have any orders for insulin and that the resident did take their oral hypoglycemic medications as ordered that month, which was when their Admission MDS was completed. A record review of the website Victoza.com revealed that the medication, Victoza, was a once-daily noninsulin medication medicine that lowers blood sugar and A1c. A record review of a facility provided policy MDS Policy with a revision date of March 2019, revealed a policy statement of To ensure the timeliness and accuracy of all MDS's, facility staff will follow the guidelines laid out in the Resident Assessment Instrument (RAI) Manual.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09C1c Based on record review and interview; the facility failed to revise 1 (Resident 23) of 12 sampled residents' care plan when the resident was treated for a urinary tract infection. The facility census was 34. The Findings Are: A record review of Resident 23's Admission Record revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of Unspecified Dementia, mild, with psychotic disturbance. A record review of a document scanned into Resident 23's electronic health record (EHR) titled Urine Dip Report and dated 3/26/24 revealed the resident's urine was red and hazy and that the resident had symptoms of blood in the urine and painful urination. A record review of a document scanned into Resident 23's EHR titled Urinalysis revealed a urinalysis, a physical, chemical, and microscopic examination of urine, was obtained on 3/26/24 and the culture of the urine was finalized on 3/31/24. A record review of Resident 23's Physician's Orders revealed the resident was treated with the antibiotics Bactrim DS for 5 days beginning on 3/30/24 and Keflex for 5 days beginning on 4/5/24. Both of the antibiotics were ordered for a diagnosis of urinary tract infection (UTI). A record review of facility provided policy Care Planning with revision date of March 2019 revealed in the Procedure section, #11. Care Plans should be updated between care conferences to reflect current care needs of the individual resident as changes occur. A record review conducted on 4/8/24 of Resident 23's undated Care Plan revealed no evidence of the care plan being updated in regard to the resident's UTI or antibiotic use. An interview on 4/9/24 at 4:45 PM with the Director of Nursing confirmed that Resident 23's Care Plan should have been updated with new interventions when the resident was diagnosed and treated for the UTI.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.09D1c Based on observations, record review and interview; the facility failed to provide timely repositioning and feeding assistance for Residents 4, 15 and 27 and toileting assistance/incontinence management for Residents 4 and 15 who all required assistance with activities of daily living (ADLs). The sample size was 3 and the facility census was 34. Findings are: A. Review of Resident 4's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 2/16/24 revealed diagnoses of chronic pain, anemia, chronic obstructive pulmonary disease (COPD), anxiety, depression, and dementia. In addition, the resident required supervision and/or touching assistance with eating and drinking, and was dependent with oral and toileting hygiene, dressing, bed mobility, personal hygiene, and transfers. The resident was assessed as frequently incontinent of bowel and bladder. Review of Resident 4's current, undated Care Plan revealed the resident had limited physical mobility and limited ability to perform ADLs related to dementia, history of a fall with hip fracture and osteoporosis. The following interventions were identified: -total staff assistance as needed with eating/drinking, -extensive assistance of 2 staff with bed mobility/repositioning, -extensive assistance of 2 staff with toileting, -extensive staff assistance with transfers, -extensive staff assistance with dressing, and -extensive to total staff assistance with personal hygiene. Observations of Resident 4 on 4/7/24 at the noon meal revealed the following: -12:15 PM the resident was seated in a tilt-n-space wheelchair (chair with ability to tilt the resident up to 30-60 degrees, while maintaining hip and knee angles at 90 degrees) next to the assisted, dining room table. The resident's chair was tilted approximately 30 degrees and bilateral foot pedals were elevated. A sippy cup with water and a container of Ensure Nutritional Supplement were positioned on the table in front of the resident. The wheelchair had been pushed away from the table, and the resident was unable to access and/or reach the drinks, Resident 4 attempted multiple times to reach out and to grasp the table to pull the wheelchair closer but was unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12:30 PM the resident's meal of mashed potatoes with gravy, and ground meat with gravy was served. Resident 4 remained unable to reach the table. -12:35 PM Nurse Aide (NA)-C offered the resident a bite of the mashed potatoes. NA-C then walked away from the resident and proceeded to help with meal intakes for Residents 5, 7 and 15 who were positioned at the same table as Resident 4. NA-C continued to rotate between the residents offering each 1-2 bites of food before continuing to assist the next resident. NA-C was the only staff available at the assisted table providing the residents assistance with intakes. NA-C finally positioned Resident 4 closer to the table, but the resident made no attempt to eat and/or to drink independently and sat with eyes closed. No further attempts were made to assist the resident to eat or drink. -12:58 PM the resident was assisted out of the dining room. The resident had consumed only bites of the noon meal. Observations of Resident 4 on 4/8/24 revealed the following: -7:35 AM the resident was seated in a tilt-n-space wheelchair in the dining room for the breakfast meal. -9:25 AM the resident remained in the wheelchair and was positioned in the dining room. The resident has been pushed away from the table and had eyes closed as if asleep. -9:50 AM the resident was assisted out of the dining room and positioned in front of the Nurse's Station. -10:28 AM the resident remained in front of the Nurse's Station. The resident moaned softly and used hands to comb thru the resident's hair and then clutched pelvic area before closing eyes and remaining still. -11:05 AM the resident's positioning remained unchanged. Further observations revealed the resident had not been provided assistance with repositioning and/or toileting and was not checked for incontinence since the resident was first observed in the dining room at 7:35 AM (3.5 hours). -11:40 AM the resident was assisted into the dining room and positioned at a table for the noon meal. -12:30 PM the resident was served the noon meal. -12:34 PM the Social Service Director (SSD) provided the resident total assistance with intake of the noon meal. -12:56 PM the resident was assisted out of the dining room and was positioned back in front of the Nurse's Station. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1:35 PM Resident 4 remained seated in the wheelchair in front of the Nurse's Station. Nurse Aide (NA)-C and Medication Aide (MA)-A assisted the resident to the resident's room. The resident was provided total assistance to transfer onto the bed. The resident's slacks were saturated with urine and stained with feces. Staff removed the resident's slacks and when the staff attempted to remove the disposable incontinence brief, the brief was stuck to the resident's skin. NA-C proceeded to use multiple pre-moistened cleansing cloths to provide hygiene cares to the resident's perineal and buttocks area and to remove feces which had dried on the resident's skin. The resident's skin to the buttocks and perineal area were red and appeared to be irritated but no skin breakdown was observed. The resident was provided a clean incontinence brief and slacks and was then positioned on the resident's right side in bed. During an Interview on 4/8/24 at 1:43 PM, with NA-C and MA-A identified the following regarding Resident 4: -required total staff assistance with eating/drinking. -no longer toileted due to advanced stage of dementia, instead the staff were to lay the resident down and provide with incontinence management. -was assisted out of bed that morning at 7:00 AM. -normally would normally lay the resident down after breakfast and after the noon meal and check for incontinence. -the resident had not been repositioned and/or provided incontinence management from 7:00 AM until 1:35 PM (6.5 hours). During an interview on 4/8/24 at 4:30 PM, the Director of Nursing (DON) revealed Resident 4 should have been repositioned and/or assessed for incontinence at least every 2 hours. In addition, the resident should have been provided increased assistance in the dining room with meal intakes to maintain the resident's nutritional status. 49263 B. A record review of Resident 27's Admission Record revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery. A record review of Resident 27's Minimum Data Set (MDS, a federally mandated assessment tool utilized for care planning), dated 3/11/24, revealed in Section GG that the resident required partial/moderate assistance with eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 4/7/24 beginning at 12:14 PM revealed Resident 27 sitting at a table in the dining room with their eyes closed. NA-C put a plate of food on the table in front of the resident and cut up the chicken that was on the plate. NA-C attempted to wake the resident by saying their name and gently shaking the resident's shoulder, then walked away from the resident's table. The resident did not respond or open their eyes. A continued observation on 4/7/24 at 12:26 PM revealed Resident 27 continued to have their eyes closed with their food still sitting in front of them, uneaten. No staff had reapproached the resident during this time. A continued observation on 4/7/24 at 12:31 PM revealed Resident 27 opening their eyes, looking around, then closing their eyes again. The food was still sitting in front of the resident, uneaten, and no staff had reapproached the resident. A continued observation on 4/7/24 at 12:48 PM revealed Resident 27 with their eyes still closed, the same uneaten food in front of them, and no staff had reapproached the resident. A continued observation on 4/7/24 at 12:51 PM revealed NA-C approached the resident at that time and woke the resident. NA-C asked the resident if they wanted something else to eat, walked over to the kitchen, then went to the table next to Resident 27's table and began assisting another resident without reapproaching Resident 27. A continued observation on 4/7/24 at 12:53 PM revealed Resident 27 had closed their eyes again and had not begun eating their food. A continued observation on 4/7/24 at 12:56 PM revealed NA-C moved Resident 27's plate away from the resident, placed a bowl of soup in front of the resident, and then walked away. Resident 27 looked at the soup and then closed their eyes again. A continued observation on 4/7/24 at 1:01 PM revealed Resident 27 with their eyes still closed and no staff had reapproached them. A continued observation on 4/7/24 at 1:20 PM revealed Resident 27 with their eyes still closed with the same bowl of soup in front of them, untouched. No staff had reapproached the resident during this time. A continued observation on 4/7/24 at 1:23 PM revealed NA-C woke Resident 27, spoke briefly to [gender], and then took the resident from the table and back to their room. The resident's soup remained uneaten and the drinks that had been on the table throughout the mealtime were not drank. An observation on 4/8/24 beginning at 8:17 AM revealed Resident 27 sitting at a dining room table with their eyes open. The resident then closed their eyes and bowed their head at 8:18 AM. A continued observation on 4/8/24 at 8:27 AM revealed Resident 27 still sitting at the table with their eyes open and with no food having been served to them yet. The resident did have two cups with straws in front of them that were full. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continued observation on 4/8/24 at 8:33 AM revealed Resident 27 still sitting at the table but had their head bowed and eyes closed. A white mashed substance in a bowl that was sitting on top of a plate and a biscuit, syrup, and butter had been placed in front of the resident but there was no staff at the table assisting the resident. A continued observation on 4/8/24 at 8:40 AM revealed MA-A waking Resident 27 and then MA-A poured the syrup into the bowl and mixed it with the food in the bowl. MA-A cued the resident to pick up their spoon and take a bite. Resident 27 then stirred the food with the spoon and then started taking bites independently. An observation on 4/8/24 at 12:50 PM revealed Resident 27 sitting in their wheelchair in their room. The resident's head was bowed, and their eyes were closed. There was an overbed table in front of the resident with a pitcher of water on it but no other food or fluids. An observation on 4/8/24 at 12:59 PM revealed Resident 27 still sitting in their wheelchair in their room with their eyes closed. A plate of food and a small cup of red liquid were sitting on the overbed table in front of the resident. There was no staff present in the resident's room and the plate of food was untouched. An observation on 4/8/24 at 1:55 PM revealed Resident 27 still sitting in the same position in their wheelchair as an hour prior with the same food sitting untouched in front of them and no staff in the room. The resident did have their eyes open at that time and was looking around their room. An observation on 4/8/24 at 2:10 PM revealed Resident 27 still sitting in the same position in their wheelchair with the same food sitting untouched in front of them and no staff in the room. The resident was watching the television in their room. An observation on 4/8/24 at 2:48 PM revealed Resident 27 sitting in their recliner with their legs elevated and their eyes closed. The plate of food was no longer in resident's room. An interview on 4/8/24 at 2:50 PM with MA-A revealed Resident 27 had eaten a couple of bites of the potato salad that had been on the plate in their room, but the resident had not wanted to eat anything else. An observation on 4/9/24 at 8:55 AM revealed Resident 27 sitting in their recliner with their eyes open and looking toward the television, which was not turned on. There was water in a pitcher on the resident's overbed table that was positioned near the resident. An observation on 4/9/24 at 9:34 AM revealed Resident 27 sitting in their recliner with their eyes closed. There was a plate with cut up sausage and a bowl with hot cereal sitting on the overbed table in front of the resident. An observation on 4/9/24 at 10:31 AM revealed Resident 27 still sitting in their recliner, their feet had been elevated, and their eyes were closed. The plate and bowl were sitting on a counter near the resident's door with all of the food still remaining. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 4/9/24 at 3:30 PM with the DON revealed Resident 27 had had a stomach bug since the previous Friday and had not been eating as well as they normally did, and that the resident's fluid intake had been hit and miss. The DON revealed that when residents who normally eat independently were not eating well, the DON's expectation would be for staff to assist the resident. An interview on 4/10/2024 at 9:08 AM with NA-K revealed Resident 27 occasionally ate in their room but their level of assistance needed varied by day depending on the resident's alertness and that the staff would check on the resident to see their progress with eating and if the resident had not eaten, the staff would provide feeding assistance. 49766 C. A record review of an Admission Record indicated the facility admitted Resident 15 on 11/15/2019 with diagnoses that included Dementia, atrial fibrillation, heart failure, and history of falls. A record review of Resident 15's annual Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), with an Assessment Reference Date (ARD) of 1/6/2024, revealed Resident 15 had severed impairment of cognitive skills for daily decision making. The MDS also revealed Resident 15 required max assistance with toileting and personal hygiene. It also revealed Resident 15 was frequently incontinent of bowel and bladder. A record review of Resident 15's Activities of Daily Living (ADL) Care Plan, with a date initiated on 11/15/2019, revealed Resident 15 required limited to extensive assist of 1 staff for toileting. A continuous observation on 4/8/2024 from 8:20 AM to 10:20 AM revealed Resident 15 had not been assisted with toileting. An interview on 4/8/2024 at 3:10 PM with Medication Aide (MA)-B revealed MA-B toilets residents twice a day and Resident 15 had last been toileted prior to breakfast. A continuous observation on 4/9/2024 from 7:07 AM to 9:47 AM revealed Resident 15 had not been assisted with toileting. An interview on 4/9/2024 at 9:47 AM with NA-L confirmed Resident 15 had not been toileted since before breakfast.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference Number 175 NAC 12-006.09D2b Based on observations, record review, and interviews; the facility failed to implement interventions per the facility's policy and the resident's care plan for 1 (Resident 3) of 3 sampled residents to promoting the healing of their pressure ulcer. The facility census was 34. The findings are: A record review of Resident 3's Admission Record revealed the resident was admitted to the facility on [DATE] with a diagnosis of complete paraplegia, which is an Injury between spinal nerves T1 and T6 that causes the hips and legs to be paralyzed and have no feeling at all. This also causes loss of bladder and bowel control. The resident had a primary diagnosis added on 9/22/2021 of a stage 4 pressure ulcer of contiguous site of back, buttock and hip. A record review of a facility provided policy Prevention of Pressure Ulcers Policy with revision date of March 2019 revealed in General Guidelines, #1. Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time causing increased pressure or a decrease of circulation (blood flow) to that area and subsequent destruction of tissue. The policy section labeled Interventions and Preventive Measures- General Preventive Measures revealed that when a person was in bed, they should change positions at least every two hours or more frequently if needed and should raise the head of the bed as little and for as short a time as possible. This section also revealed that when a person was in a chair, they should change positions at least every hour. A record review of Resident 3's undated Care Plan revealed the resident's skin was at risk for breakdown due to their diagnosis of paraplegia and fecal incontinence and that the resident had a stage 4 pressure ulcer (Full thickness tissue loss with exposed bone, tendon, or muscle) to their right ischium, the large bone in the lower part of the hip. The Care Plan revealed interventions including a pressure redistribution mattress to the resident's bed, daily dressing changes, follow facility policies/protocols for the prevention/treatment of skin breakdown, and staff were to encourage the resident to shift their position frequently while in their wheelchair (WC) and were to assist the resident to turn/reposition at least every 2 hours and more often as needed or requested. An observation on 4/7/24 at 12:37 PM revealed Medication Aide (MA)-B took a plate of food, a cup of coffee and silverware into Resident 3's room and placed them on the overbed table, which was in front of the resident, who was lying in bed. The resident asked MA-B to take their pillow out from under their right side. MA-B removed the pillow and repositioned the resident onto their back with the head of the bed (HOB) elevated so they could eat. An interview on 4/7/24 at 2:06 PM with Resident 3 revealed the resident had a wound on their right buttock and that they weighed 109 pounds when staff weighed them on 4/2/24. Resident 3 also confirmed that they were unable to reposition their body on their own due to their paraplegia and contractures to their hands and legs. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 4/7/24 at 2:06 PM revealed Resident 3 laying in their bed on their back with the head of the bed (HOB) elevated to greater than 30 degrees. The resident's air mattress was set at 250 pounds. An interview on 4/8/24 at 8:24 AM with the Director of Nursing (DON) confirmed that Resident 3 usually only got out of bed once a day for the noon meal and that the resident stayed in bed the rest of the time. The DON stated the resident had dressing changes to the wound on their buttock/ischium that were done each day either before the resident got up for lunch or after they were laid back down. An observation on 4/8/24 at 10:29 AM revealed Resident 3 lying flat on their back in their bed with the HOB elevated at greater than 30 degrees. Resident 3's air mattress was set to 250 pounds. An observation on 4/8/24 at 12:05 PM revealed Resident 3 sitting upright in their WC at their table in the dining room. An observation on 4/8/24 at 1:01 PM revealed staff pushing Resident 3 in their WC to their room. The resident's WC was positioned so the resident could see their television and remained in the upright position. An observation on 4/8/24 at 1:56 PM revealed Resident 3 remained in the same upright position in their WC in their room. An observation on 4/8/24 at 2:49 PM revealed Resident 3 was lying on their back in their bed with the HOB elevated at approximately 30 degrees. An observation on 4/9/24 at 7:26 AM revealed Resident 3 lying in their bed with the HOB elevated to approximately 30 degrees and a pillow under the right side of their body. Their air mattress was set at 250 pounds. An observation on 4/9/24 at 8:48 AM revealed Resident 3 lying in their bed with the HOB elevated to approximately 30 degrees and a pillow under the right side of their body. An observation on 4/9/24 at 9:32 AM revealed Resident 3 lying in their bed with the HOB elevated to approximately 30 degrees and a pillow under the right side of their body. An observation on 4/9/24 at 10:33 AM revealed Resident 3 lying in their bed with the HOB elevated to approximately 30 degrees and a pillow under the right side of their body. An observation on 4/9/24 at 11:30 AM revealed Resident 3 lying in their bed with the HOB elevated to approximately 30 degrees and a pillow under the right side of their body. An observation on 4/9/24 at 12:00 PM revealed Resident 3 lying in their bed with the HOB elevated to approximately 30 degrees and a pillow under the right side of their body. Their air mattress was set at 250 pounds and their position was unchanged from the previous 4.5 hours. An observation on 4/9/24 at 12:37 PM revealed Resident 3 sitting upright in their WC at a table in the dining room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 4/9/24 at 2:15 PM revealed Resident 3 sitting upright in their WC in their room and watching TV. An observation on 4/9/24 at 3:05 PM revealed Resident 3 sitting upright in their WC in their room and watching TV. Their position in the WC was unchanged from the previous 2.5 hours. An interview on 4/9/24 at 3:25 PM with the DON revealed that Resident 3 had a bowel movement that morning at shift change, so the night nurse had changed the dressing to their buttock/ischium. The DON also confirmed that the nursing staff had just finished laying the resident down in bed at that time. An observation on 4/10/24 at 7:30 AM revealed Resident 3 lying at a slight angle toward their right side in their bed with the HOB elevated to greater than 30 degrees. The resident's air mattress continued to be set at 250 pounds. An observation on 4/10/24 at 8:30 AM revealed Resident 3 lying at a slight angle toward their right side in their bed with the HOB elevated to greater than 30 degrees. An observation on 4/10/24 at 9:36 AM revealed Resident 3 lying at a slight angle toward their right side in their bed with the HOB elevated to greater than 30 degrees. An interview on 4/10/24 at 9:55 AM with the DON revealed the resident was not feeling well that day and the facility had just had to cancel the resident's appointment with the wound clinic that was scheduled for later in the day. An observation on 4/10/24 at 10:27 AM revealed Resident 3 lying at a slight angle toward their right side in their bed with the HOB elevated to greater than 30 degrees. Their position was unchanged from their positioning over the previous three hours. An interview on 4/10/24 at 10:46 AM with the DON confirmed the resident was lying on an air mattress and that it should be set at approximately 120 pounds, and that the mattress was to be set based on the resident's weight. The DON confirmed that the air mattress was set at 250 pounds at that time. The DON also confirmed that the resident's HOB was elevated to approximately 45 degrees. The DON revealed that their expectation was for staff to reposition the resident at a minimum of every two hours whether they were in their bed or their wheelchair.

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.09D8b Based on observations, record review and interview; the facility failed to implement, evaluate and/or revise nutritional interventions to address ongoing and significant weight loss for 3 (Residents 3, 4 and 27) of 4 sampled residents. The facility census was 34. Findings are: A. Review of a Weight Assessment policy with a revision date of 3/19 revealed it was the policy of the facility to prevent, monitor, and intervene to prevent undesirable weight loss for the residents. The following procedure was identified regarding weight assessment: -staff were to measure the resident's weight on admission, the next day and then weekly thereafter, -the weights were to be recorded in each resident's individual medical record, -any weight change of 5 percent (%) or more since the previous weight would be retaken the next day. If the weight was confirmed, the Registered Dietician (RD) was to be notified in writing, -the RD was to review the weight record by the 15th of the month and evaluate for significant weight changes, and -the threshold for significant unplanned and undesired weight loss would be based on the following criteria: 5% weight loss in 1 month would be considered significant and greater than 5% severe, 7.5% loss in 3 months was significant and greater than 7.5% severe, and 10% in 6 months was significant and weight loss greater than 10% would be considered severe. Interventions to address undesirable weight loss were to be based on the following: -resident choice and preferences, -nutrition and hydration need, -functional factors that may inhibit independence with eating, -environmental factors that could inhibit appetite, -chewing and swallowing abnormalities, -medications, -use of supplements, and (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	-end of life decisions. B. Review of Resident 4's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 2/16/24 revealed diagnoses of chronic pain, anemia, chronic obstructive pulmonary disease (COPD), anxiety, depression and dementia and the resident had a weight of 92 pounds (lbs.). In addition, the assessment indicated the resident had an order for a mechanically altered diet (a type of texture-modified diet for people who have difficulty chewing and swallowing) and required supervision and/or touching assistance with eating and drinking. Resident 4 did not have a condition or a chronic disease that could result in a life expectancy of less than 6 months. Review of Resident 4's current, undated Care Plan revealed the resident had a potential for nutritional problems related to dementia and poor appetite. The following interventions were identified: -provide and serve nutritional supplements (Ensure to be provided twice a day) as ordered, -Registered Dietican (RD) to evaluate and make changes as needed, -monitor intake and record with each meal, -provide total staff assistance as needed with eating/drinking, -provide sippy cups with lids and straws, -resident prefers to have snacks between meals, -provide diet as ordered (no added salt, mechanical soft with thin liquids), and -weight weekly. Review of Resident 4's Weights and Vitals Summary Sheet (form used to document a resident's weight, blood pressure, respiration, temperature, and pulse) revealed the following regarding the resident's weight: -9/27/23 weight was 92 lbs. -10/8/23 weight was 88 lbs. -12/21/23 weight was 85 lbs. (7.6% loss in 3 months) -1/19/24 weight was 82 lbs. -2/5/24 weight was 83 lbs. (9.8% loss in 5 months) Further review of the resident's Weights and Vitals Summary Sheet revealed from 2/6/24 through 4/5/24, there was no further documentation in the electronic medical records of the resident's weights. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	Review of a Nutritional Risk Screen dated 2/19/24 at 2:17 PM confirmed the Resident 4's most recent, documented weight was 83 lbs. The screen completed by the RD did not identify the residents significant weight loss and no dietary changes were recommended despite the residents ongoing weight loss. Review of handwritten documents titled Weekly Bath Sheet from 2/18/24 to 4/5/24 revealed the following: -received a bath on 2/23/24 with a weight of 84 lbs. -received a bath on 3/1/24 with a weight of 82 lbs. -received a bath on 3/6/24 with a weight of 82 lbs. -received a bath on 3/15/24 with a weight of 84 lbs. -received a bath on 3/29/24 with a weight of 84 lbs. -received a bath on 4/5/24 with a weight of 82 lbs. Review of the resident's meal intakes for the breakfast meal from 3/11/24 through 4/6/24 revealed the following regarding the resident's intakes: -consumed 0-25% on 3/16 and on 4/3/24, -consumed 26-50% on 3/26 and on 3/21/24, and -no documentation of the resident's meal intakes on 3/13, 3/14, 3/17, 3/18, 3/19, 3/23, 3/24, 3/27, and on 3/28/24 (9 out of 25 meals provided). Review of meal intakes for the noon meal from 3/11/24 through 4/6/24 revealed the following regarding meal intakes: -consumed 0-25% on 3/26, 3/29, 3/30, 3/31, 3/16, 3/20, 3/21, 3/22, and 4/4/24 (9 out of 21 meals provided), -consumed 26-50% on 3/12, 3/15, 3/25, 4/1, 4/2, and 4/3/24 (6 out of 21 meals), and -no documentation of the resident's meal intakes on 3/13, 3/14, 3/17, 3/18, 3/19, 3/23, 3/24, 3/27, and 3/28/24 (9 out of 21 days). Review of Resident 4's evening meal intakes from 3/11/24 to 4/4/24 revealed the following: -consumed 0-25% on 3/16, 3/20, 3/21, 3/22, and 4/2/24 (5 out of 21 days), -consumed 26-50% on 3/11, 3/25, 3/30, and 4/1/24 (4 out of 21 meals served), (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	-no documentation of the resident's meal intakes on 3/14, 3/15, 3/18, 3/19, 3/23, 3/24, 3/27, 3/28, 3/31 and 4/4/24 (10 out of the 21 days the meal was offered). Observations of Resident 4 on 4/7/24 at the noon meal revealed the following: -12:15 PM the resident was seated in a tilt-n-space wheelchair (chair with ability to tilt the resident up to 30-60 degrees, while maintaining hip and knee angles at 90 degrees) next to the assisted, dining room table. The resident's chair was tilted approximately 30 degrees and bilateral foot pedals were elevated. A sippy cup with water and a container of Ensure Nutritional Supplement were positioned on the table in front of the resident. The wheelchair had been pushed away from the table, and the resident was unable to access and/or reach the drinks, Resident 4 attempted multiple times to reach out and to grasp the table to pull the wheelchair closer but was unable. -12:30 PM the resident's meal of mashed potatoes with gravy, and ground meat with gravy was served. Resident 4 remained unable to reach the table. -12:35 PM Nurse Aide (NA)-C offered the resident a bite of the mashed potatoes. NA-C then walked away from the resident and proceeded to help with meal intakes for Residents 5, 7 and 15 who were positioned at the same table as Resident 4. NA-C continued to rotate between the residents offering each 1-2 bites of food before continuing to assist the next resident. -12:58 PM the resident was assisted out of the dining room. The resident had consumed only bites of the noon meal but did consume 100% of the Ensure Supplement. During an interview on 4/8/24 at 4:30 PM with the Director of Nursing (DON) confirmed the following: -the resident should have been provided increased and timely assistance with eating/drinking the resident's noon meal on 4/7/24. -the nursing staff were responsible for documenting the resident's meal intakes after each meal. -the facility did not have a qualified Dietary Manager (DM) and the RD was to come to the facility every other week. -the RD was responsible for reviewing the resident's weights and was to notify the nursing staff if a weight loss was identified. -the resident's weights were to be obtained weekly with the resident's bath and then documented in the electronic medical record. -the DON was unaware the resident's weights were not being documented in the electronic medical record and was not aware of the resident's significant weight loss. -the RD would not have had access to the handwritten bathing schedules with the resident's weights and did not identify the resident had no documented weight since 2/5/24 or had a significant weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	-there was no documented evidence the RD had provided further assessment and monitoring of the resident's nutritional status and weight loss since the Nutritional Risk Screen completed 2/19/24 at 2:17 PM. -no additional interventions were developed to address the resident's ongoing and significant weight loss. 49263 C. A record review of Resident 27's Admission Record revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery. A record review of Resident 27's MDS, dated [DATE], revealed in Section K that the resident had not had a weight loss and that they were on a therapeutic diet. Section GG revealed that the resident required partial/moderate assistance with eating. A record review of Resident 27's Physician's Orders revealed the resident was on a Consistent Carbohydrate diet and that the resident was not receiving any dietary supplements. The resident also had an order, with a start date of 11/30/2022 that stated to obtain the resident's weight monthly. A record review of Resident 27's undated Care Plan revealed the resident had a goal to have no significant weight loss of 5% in 30 days or 10% in 180 days and interventions to meet this goal included for staff to monitor the resident's intake and to record every meal. On 3/7/2023, a focus was added of I am independent in eating with interventions including I eat in the dining room and I want staff to monitor for changes in my ability to eat independently or safely. There was also an intervention, initiated on 12/14/2022, that stated to weight the resident weekly. A record review of Resident 27's most recent Nutritional Screen Assessment, completed on 3/18/24 by the RD revealed documentation that the resident had not had any weight loss and that the resident's average food intake over the prior 7 days had been 75-100%. A record review conducted on 4/9/24 of Resident 27's Task: Nutrition- Breakfast revealed there was no documentation for 10 of the previous 30 days. The resident consumed less than 50% of their meal on 8 days and there was no alternate food offered according to the documentation. A record review conducted on 4/9/24 of Resident 27's Task: Nutrition- Lunch revealed there was no documentation for 10 of the previous 30 days. The resident consumed less than 50% of their meal on 7 days with the resident being offered an alternate food only one of those days. The resident did consume over 75% of the alternate food that day. A record review conducted on 4/9/24 of Resident 27's Task: Nutrition- Dinner revealed there was no documentation for 11 of the previous 30 days. The resident consumed less than 50% of their meal on 8 days with the resident being offered an alternate food 6 of those days. The resident consumed 25% or less of the alternates offered. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Indian Hills Manor	1720 North Spruce Ogallala, NE 69153

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F 0692 Level of Harm - Actual harm Residents Affected - Some	A record review conducted on 4/9/24 of Resident 27's Task: Nutrition- HS (hour of sleep) Snacks revealed there was no documentation for 9 of the previous 30 days. The resident consumed an HS snack one time according to the documentation. A record review of a document provided by the facility administrator on 4/9/24 revealed Resident 27 had not had a weight documented in their electronic health record since 3/4/24. A record review of a document provided by [NAME] President of Operations(VPO)-H titled Weekly Bath Sheet and dated March 3rd-9th revealed Resident 27 had a bath on 3/4/24 with a weight documented of 144 pounds. The resident also had a bath on 3/9/24 with a weight documented of 142.5 pounds. There were no other baths or weights documented that week. A record review of a document provided by VPO-H titled Weekly Bath Sheet and dated March 10th-16th revealed Resident 27 had a bath on 3/16/24 with a weight documented of 137.5 pounds. There were no other baths or weights documented that week. A record review of a document provided by VPO-H titled Weekly Bath Sheet and dated March 17th-23rd revealed Resident 27 did not received any baths that week and had no weights documented. A record review of a document provided by VPO-H titled Weekly Bath Sheet and dated March 24th-30th revealed Resident 27 had a bath on 3/25/24 with a weight documented of 135.5 pounds. There were no other baths or weights documented that week. A record review of a document provided by VPO-H titled Weekly Bath Sheet and dated March 31st- April 6th revealed Resident 27 had a bath on 4/6/24 but there was no weight documented. There were no other baths or weights documented that week. A record review conducted on 4/10/24 of a document provided by VPO-H titled Weekly Bath Sheet and dated April 7th-13th revealed Resident 27 had not had a bath yet that week and had no weights documented. Based on the record review of Resident 27's weights of 144 pounds on 3/4/24 and 135.5 pounds on 3/25/24, the resident had a 5.9% weight loss in less than one month. A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual revealed a weight change of 5% in 1 month was a significant amount of weight loss and should prompt a thorough assessment of the resident's nutritional status. An observation on 4/7/24 beginning at 12:14 PM revealed Resident 27 sitting at a table in the dining room with their eyes closed. NA-C put a plate of food on the table in front of the resident and cut up the chicken that was on the plate. NA-C attempted to wake the resident by saying their name and gently shaking the resident's shoulder, then walked away from the resident's table. The resident did not respond or open their eyes. A continued observation on 4/7/24 at 12:26 PM revealed Resident 27 continued to have their eyes closed with their food still sitting in front of them, uneaten. No staff had reapproached the resident during this time. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	A continued observation on 4/7/24 at 12:31 PM revealed Resident 27 opening their eyes, looking around, then closing their eyes again. The food was still sitting in front of the resident, uneaten, and no staff had reapproached the resident. A continued observation on 4/7/24 at 12:48 PM revealed Resident 27 with their eyes still closed, the same uneaten food in front of them, and no staff had reapproached the resident. A continued observation on 4/7/24 at 12:51 PM revealed NA-C approached the resident at that time and woke the resident. NA-C asked the resident if they wanted something else to eat, walked over to the kitchen, then went to the table next to Resident 27's table and began assisting another resident without reapproaching Resident 27. A continued observation on 4/7/24 at 12:53 PM revealed Resident 27 had closed their eyes again and had no begun eating their food. A continued observation on 4/7/24 at 12:56 PM revealed NA-C moved Resident 27's plate away from the resident, placed a bowl of soup in front of the resident, and then walked away. Resident 27 looked at the soup and then closed their eyes again. A continued observation on 4/7/24 at 01:01 PM revealed Resident 27 with their eyes still closed and no staff had reapproached them. A continued observation on 4/7/24 at 1:20 PM revealed Resident 27 with their eyes still closed with the same bowl of soup in front of them, untouched. No staff had reapproached the resident during this time. A continued observation on 4/7/24 at 1:23 PM revealed NA-C woke Resident 27, spoke briefly to them, and then took the resident from the table and back to their room. The resident's soup remained uneaten and the drinks that had been on the table throughout the mealtime were not drank. An observation on 4/8/24 beginning at 8:17 AM revealed Resident 27 sitting at a dining room table with their eyes open. The resident then closed their eyes and bowed their head at 8:18 AM. A continued observation on 4/8/24 at 8:27 AM revealed Resident 27 still sitting at the table with their eyes open and with no food having been served to them yet. The resident did have two cups with straws in front of them that were full. A continued observation on 4/8/24 at 8:33 AM revealed Resident 27 still sitting at the table but had their head bowed and eyes closed. A white mashed substance in a bowl that was sitting on top of a plate and a biscuit, syrup, and butter had been placed in front of the resident but there was no staff at the table assisting the resident. A continued observation on 4/8/24 at 8:40 AM revealed MA-A waking Resident 27 and then MA-A poured the syrup into the bowl and mixed it with the food in the bowl. MA-A cued the resident to pick up their spoon and take a bite. Resident 27 then stirred the food with the spoon and then started taking bites independently. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	An observation on 4/8/24 at 12:50 PM revealed Resident 27 sitting in their wheelchair in their room. The resident's head was bowed, and their eyes were closed. There was an overbed table in front of the resident with a pitcher of water on it but no other food or fluids. An observation on 4/8/24 at 12:59 PM revealed Resident 27 still sitting in their wheelchair in their room with their eyes closed. A plate of food and a small cup of red liquid were sitting on the overbed table in front of the resident. There was no staff present in the resident's room and the plate of food was untouched. An observation on 4/8/24 at 1:55 PM revealed Resident 27 still sitting in the same position as an hour prior with the same food sitting untouched in front of them and no staff in the room. The resident did have their eyes open at that time and was looking around their room. An observation on 4/8/24 at 2:10 PM revealed Resident 27 still sitting in the same position with the same food sitting untouched in front of them and no staff in the room. The resident was watching the television in their room. An observation on 4/8/24 at 2:48 PM revealed Resident 27 sitting in their recliner with their legs elevated and their eyes closed. The plate of food was no longer in resident's room. An interview on 4/8/24 at 2:50 PM with MA-A revealed Resident 27 had eaten a couple of bites of the potato salad that had been on the plate in their room, but the resident had not wanted to eat anything else. An observation on 4/9/24 at 8:55 AM revealed Resident 27 sitting in their recliner with their eyes open and looking toward the television, which was not turned on. There was water in a pitcher on the resident's overbed table that was positioned near the resident. An observation on 4/9/24 at 9:34 AM revealed Resident 27 sitting in their recliner with their eyes closed. There was a plate with cut up sausage and a bowl with hot cereal sitting on the overbed table in front of the resident. An observation on 4/9/24 at 10:31 AM revealed Resident 27 still sitting in their recliner, their feet had been elevated, and their eyes were closed. The plate and bowl were sitting on a counter near the resident's door with all of the food still remaining. An interview on 4/9/24 at 3:30 PM with the DON revealed Resident 27 had had a stomach bug since the previous Friday and had not been eating as well as they normally did, and that the resident's fluid intake had been hit and miss. The DON revealed that when residents who normally eat independently were not eating well, the DON's expectation would be for staff to assist the resident. An interview on 4/10/2024 at 9:08 AM with NA-K revealed Resident 27 occasionally ate in their room but their level of assistance needed varied by day depending on the resident's alertness and that the staff would check on the resident to see their progress with eating and if the resident had not eaten, the staff would provide feeding assistance. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	An interview on 4/10/24 at 9:50 AM with the DON confirmed that the bath aides were supposed to transfer weights that were written on the bath sheets into each resident's electronic health record in Point Click Care (PCC). The DON confirmed there was no one verifying that the weights were being entered in PCC. The DON confirmed they were not aware of Resident 27's recent weight loss prior to the interview. 49766 D. A record review of an Admission Record indicated the facility admitted Resident 14 on 1/17/2020 with diagnoses of Dementia, Parkinson's disease, delusional disorder, Major Depressive Disorder, anxiety, heart failure, and Chronic Obstructive Pulmonary Disease. A record review of Resident 14's weights revealed the following: - 10/21/2023: 169.5 lb - 11/23/2023: 159.5 lb - 12/27/2023: 153 lb - 1/30/2024: 146.5 lb - 2/28/2024: 143.5 lb - 3/27/2024: 141 lb (-16.81% loss over 6 months) A record review of a Nutritional Evaluation with a date of 1/9/2024 confirmed a significant weight loss of 56 pounds over past year and referred to Care Plan for nutritional plan. A record review of Resident 14's Activities of Daily Living Care Plan revealed Resident 14 had an ADL self-care performance deficit related to loose fitting dentures, tremors in hands, and limited mobility. The interventions included Resident 14 required assistance by 1 staff to eat with a date initiated of 9/3/2023. An interview on 4/7/2024 at 3:02 PM with Resident 14's family member revealed Resident 14 needs cued to open mouth during feeding as Resident 14 does not open mouth very well and tremors have made it difficult to eat independently. An observation on 4/8/2024 at 12:39 PM revealed NA-A had stopped feeding assistance to go outside. An observation on 4/8/2024 at 12:47 PM revealed NA-A had stopped feeding assistance to go outside. An observation on 4/8/2024 at 12:56 PM revealed NA-A had stopped feeding assistance to resident while being on personal cellphone. An observation on 4/8/2024 at 1:01 PM revealed Resident 14 had ate less than 25% of the meal. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Some	An interview on 4/9/2024 at 9:48 with NA-A revealed Resident 14 needs assistance with feeding since the last six to twelve months due to an increase in tremors and inability to feed self. An interview on 4/9/2024 at 5:00 PM with DON revealed expectation would be for aides to assist with feeding uninterrupted according to Care Plan for interventions. A record review of Resident 14's Nutritional Care Plan, initiated on 7/10/2023, revealed Resident 14 had a potential nutritional problem for weight loss related to confusion with an intervention to monitor intake and record each meal. A record review of meal intakes revealed there were no meal intakes charted for breakfast or lunch on 4/6/2024, 4/7/2024, or 4/8/2024.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.04C Based on observations, record review and interviews; the facility failed to ensure sufficient staff were available to provide Residents 3, 4 and 27 with timely feeding assistance, repositioning, and incontinence cares. The total sample size was 19 and the facility census was 34. Findings are: A. Review of Resident 4's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 2/16/24 revealed diagnoses of chronic pain, anemia, chronic obstructive pulmonary disease (COPD), anxiety, depression, and dementia. In addition, the resident required supervision and/or touching assistance with eating and drinking, and was dependent with oral and toileting hygiene, dressing, bed mobility, personal hygiene, and transfers. The resident was assessed as frequently incontinent of bowel and bladder. Review of Resident 4's current, undated Care Plan revealed the resident had limited physical mobility and limited ability to perform ADLs related to dementia, history of a fall with hip fracture and osteoporosis. The following interventions were identified: -total staff assistance as needed with eating/drinking, -extensive assistance of 2 staff with bed mobility/repositioning, -extensive assistance of 2 staff with toileting, -extensive staff assistance with transfers, -extensive staff assistance with dressing, and -extensive to total staff assistance with personal hygiene. Observations of Resident 4 on 4/7/24 at the noon meal revealed the following: -12:15 PM the resident was seated in a tilt-n-space wheelchair (chair with ability to tilt the resident up to 30-60 degrees, while maintaining hip and knee angles at 90 degrees) next to the assisted, dining room table. The resident's chair was tilted approximately 30 degrees and bilateral foot pedals were elevated. A sippy cup with water and a container of Ensure Nutritional Supplement were positioned on the table in front of the resident. The wheelchair had been pushed away from the table, and the resident was unable to access and/or reach the drinks, Resident 4 attempted multiple times to reach out and to grasp the table to pull the wheelchair closer but was unable. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-12:30 PM the resident's meal of mashed potatoes with gravy, and ground meat with gravy was served. Resident 4 remained unable to reach the table. -12:35 PM Nurse Aide (NA)-C offered the resident a bite of the mashed potatoes. NA-C then walked away from the resident and proceeded to help with meal intakes for Residents 5, 7 and 15 who were positioned at the same table as Resident 4. NA-C continued to rotate between the residents offering each 1-2 bites of food before continuing to assist the next resident. NA-C was the only staff available at the assisted table providing the residents assistance with intakes. NA-C finally positioned Resident 4 closer to the table, but the resident made no attempt to eat and/or to drink independently and sat with eyes closed. No further attempts were made to assist the resident to eat/drink. -12:58 PM the resident was assisted out of the dining room. The resident had consumed only bites of the noon meal. Observations of Resident 4 on 4/8/24 revealed the following: -7:35 AM the resident was seated in a tilt-n-space wheelchair in the dining room for the breakfast meal. -9:25 AM the resident remained in the wheelchair and was positioned in the dining room. The resident has been pushed away from the table and had eyes closed as if asleep. -9:50 AM the resident was assisted out of the dining room and positioned in front of the Nurse's Station. -10:28 AM the resident remained in front of the Nurse's Station. The resident moaned softly and used hands to comb thru the resident's hair and then clutched pelvic area before closing eyes and remaining still. -11:05 AM the resident's positioning remained unchanged. Further observations revealed the resident had not been provided assistance with repositioning and/or toileting and was not checked for incontinence since the resident was first observed in the dining room at 7:35 AM (3.5 hours). -11:40 AM the resident was assisted into the dining room and positioned at a table for the noon meal. -12:30 PM the resident was served the noon meal. -12:34 PM the Social Service Director (SSD) provided the resident total assistance with intake of the noon meal. -12:56 PM the resident was assisted out of the dining room and was positioned back in front of the Nurse's Station. (continued on next page)

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F 0725

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

-1:35 PM Resident 4 remained seated in the wheelchair in front of the Nurse's Station. Nurse Aide (NA)-C and Medication Aide (MA)-A assisted the resident to the resident's room. The resident was provided total assistance to transfer onto the bed. The resident's slacks were saturated with urine and stained with feces. Staff removed the resident's slacks and when the staff attempted to remove the disposable incontinence brief, the brief was stuck to the resident's skin due to level of incontinence. NA-C proceeded to use multiple pre-moistened cleansing cloths to provide hygiene cares to the resident's perineal and buttocks area and to remove feces which had dried on the resident's skin. The resident's skin to the buttocks and perineal area were red and appeared to be irritated but no skin breakdown was observed. The resident was provided a clean incontinence brief and slacks and was then positioned on the resident's right side in bed.

Review of the facility document titled Daily Staffing Assignments dated 4/7/24 revealed for the day shift (6:00 AM to 6:00 PM) the facility had one Registered Nurse (RN) Charge Nurse, 1 Nurse Aide (NA) assigned to the front corridor and 1 Medication Aide (MA) who was assigned to pass medications and to assist on the back corridor. Further review of the form revealed no documentation next to the float position, the back corridor, the Bath Aide and the Restorative Aide. The facility census was identified as 34.

Review of the Daily Staffing Assignment dated 4/8/24 for the day shift revealed the facility had 1 RN Charge Nurse, 1 MA who was passing medications and assisting on the back corrridor, 1 NA and 1 NA who worked as the Bath Aide and a float. The facility continued to have a census of 34. Further review of the form revealed no documentation to indicate a staff had been assigned to work as the Resotative Aide.

During an Interview on 4/8/24 at 1:43 PM, NA-C and MA-A identified the following regarding Resident 4 and current staffing levels:

-on 4/7/24 only 1 NA was available at the noon meal and 1 MA who assisted to deliver meal trays including room trays, answer call lights and assist the residents in the dining room with intakes when finished with the noon medication pass. Not enough staff was available to provide the residents with feeding assistance in the dining room.

-Resident 4 required total staff assistance with eating/drinking.

-Resident 4 was no longer toileted due to advanced stage of dementia, instead the staff were to lay the resident down and provide with incontinence management.

-Resident was assisted out of bed 4/8/24 at 7:00 AM.

-normally would lay the resident down after breakfast and after the noon meal and check for incontinence.

-the resident had not been repositioned and/or provided incontinence management on 4/8/24 from 7:00 AM until 1:35 PM (6.5 hours).

-required 2 staff to assist with laying down and incontinence management. Due to current staffing levels, not enough staff were available 4/8/24 to ensure the resident was provided timely incontinence management and repositioning.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/8/24 at 4:30 PM, the Director of Nursing (DON) indicated Resident 4 should have been repositioned and/or assessed for incontinence at least every 2 hours. In addition, the resident should have been provided increased assistance in the dining room with meal intakes to maintain the resident's nutritional status. The DON further indicated 3 direct care staff had recently left and the facility had not yet been able to replace these staff. 49263 B. A record review of Resident 27's Admission Record revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery. A record review of Resident 27's Minimum Data Set (MDS), a federally mandated assessment tool utilized for care planning, dated 3/11/24, revealed in Section GG that the resident required partial/moderate assistance with eating. An observation on 4/7/24 beginning at 12:14 PM revealed Resident 27 sitting at a table in the dining room with their eyes closed. NA-C put a plate of food on the table in front of the resident and cut up the chicken that was on the plate. NA-C attempted to wake the resident by saying their name and gently shaking the resident's shoulder, then walked away from the resident's table. The resident did not respond or open their eyes. A continued observation on 4/7/24 at 12:26 PM revealed Resident 27 continued to have their eyes closed with their food still sitting in front of them, uneaten. No staff had reapproached the resident during this time. A continued observation on 4/7/24 at 12:31 PM revealed Resident 27 opening their eyes, looking around, then closing their eyes again. The food was still sitting in front of the resident, uneaten, and no staff had reapproached the resident. A continued observation on 4/7/24 at 12:48 PM revealed Resident 27 with their eyes still closed, the same uneaten food in front of them, and no staff had reapproached the resident. A continued observation on 4/7/24 at 12:51 PM revealed NA-C approached the resident at that time and woke the resident. NA-C asked the resident if they wanted something else to eat, walked over to the kitchen, then went to the table next to Resident 27's table and began assisting another resident without reapproaching Resident 27. A continued observation on 4/7/24 at 12:53 PM revealed Resident 27 had closed their eyes again and had no begun eating their food. A continued observation on 4/7/24 at 12:56 PM revealed NA-C moved Resident 27's plate away from the resident, placed a bowl of soup in front of the resident, and then walked away. Resident 27 looked at the soup and then closed their eyes again. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A continued observation on 4/7/24 at 01:01 PM revealed Resident 27 with their eyes still closed and no staff had reapproached them. A continued observation on 4/7/24 at 1:20 PM revealed Resident 27 with their eyes still closed with the same bowl of soup in front of them, untouched. No staff had reapproached the resident during this time. A continued observation on 4/7/24 at 1:23 PM revealed NA-C woke Resident 27, spoke briefly to them, and then took the resident from the table and back to their room. The resident's soup remained uneaten and the drinks that had been on the table throughout the mealtime were not drank. An observation on 4/8/24 beginning at 8:17 AM revealed Resident 27 sitting at a dining room table with their eyes open. The resident then closed their eyes and bowed their head at 8:18 AM. A continued observation on 4/8/24 at 8:27 AM revealed Resident 27 still sitting at the table with their eyes open and with no food having been served to them yet. The resident did have two cups with straws in front of them that were full. A continued observation on 4/8/24 at 8:33 AM revealed Resident 27 still sitting at the table but had their head bowed and eyes closed. A white mashed substance in a bowl that was sitting on top of a plate and a biscuit, syrup, and butter had been placed in front of the resident but there was no staff at the table assisting the resident. A continued observation on 4/8/24 at 8:40 AM revealed MA-A waking Resident 27 and then MA-A poured the syrup into the bowl and mixed it with the food in the bowl. MA-A cued the resident to pick up their spoon and take a bite. Resident 27 then stirred the food with the spoon and then started taking bites independently. An observation on 4/8/24 at 12:50 PM revealed Resident 27 sitting in their wheelchair in their room. The resident's head was bowed, and their eyes were closed. There was an overbed table in front of the resident with a pitcher of water on it but no other food or fluids. An observation on 4/8/24 at 12:59 PM revealed Resident 27 still sitting in their wheelchair in their room with their eyes closed. A plate of food and a small cup of red liquid were sitting on the overbed table in front of the resident. There was no staff present in the resident's room and the plate of food was untouched. An observation on 4/8/24 at 1:55 PM revealed Resident 27 still sitting in the same position in their wheelchair as an hour prior with the same food sitting untouched in front of them and no staff in the room. The resident did have their eyes open at that time and was looking around their room. An observation on 4/8/24 at 2:10 PM revealed Resident 27 still sitting in the same position in their wheelchair with the same food sitting untouched in front of them and no staff in the room. The resident was watching the television in their room. An observation on 4/8/24 at 2:48 PM revealed Resident 27 sitting in their recliner with their legs elevated and their eyes closed. The plate of food was no longer in resident's room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 4/8/24 at 2:50 PM with MA-A revealed Resident 27 had eaten a couple of bites of the potato salad that had been on the plate in their room, but the resident had not wanted to eat anything else. An observation on 4/9/24 at 8:55 AM revealed Resident 27 sitting in their recliner with their eyes open and looking toward the television, which was not turned on. There was water in a pitcher on the resident's overbed table that was positioned near the resident. An observation on 4/9/24 at 9:34 AM revealed Resident 27 sitting in their recliner with their eyes closed. There was a plate with cut up sausage and a bowl with hot cereal sitting on the overbed table in front of the resident. An observation on 4/9/24 at 10:31 AM revealed Resident 27 still sitting in their recliner, their feet had been elevated, and their eyes were closed. The plate and bowl were sitting on a counter near the resident's door with all of the food still remaining. An interview on 4/9/24 at 3:30 PM with the DON revealed Resident 27 had had a stomach bug since the previous Friday and had not been eating as well as they normally did, and that the resident's fluid intake had been hit and miss. The DON revealed that when residents who normally eat independently were not eating well, the DON's expectation would be for staff to assist the resident. An interview on 4/10/2024 at 9:08 AM with NA-K revealed Resident 27 occasionally ate in their room but their level of assistance needed varied by day depending on the resident's alertness and that the staff would check on the resident to see their progress with eating and if the resident had not eaten, the staff would provide feeding assistance.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 49766 Based on interviews and record review; the facility failed to ensure Medication Regimen Reviews had been reviewed by the physician and a rationale was provided when no action was taken for 1 (Resident 14) of 5 sampled residents. The facility identified a census of 34. The findings are: A record review of an Admission Record indicated the facility admitted Resident 14 on 1/17/2020 with diagnoses of Dementia, Parkinson's disease, delusional disorder, Major Depressive Disorder, anxiety, heart failure, and Chronic Obstructive Pulmonary Disease. A record review of a Consultation Report with a date of 9/24/2023 revealed the Pharmacist had conducted a comprehensive medication review, but the facility had no documentation that the physician had also completed the monthly review for Resident 14. A record review of a Consultation Report with a date of 11/15/2023 revealed the Pharmacist had concerns regarding Resident 14's citalopram and risperidone. The facility had no documentation that they physician had reviewed or responded to the concerns. An interview on 4/10/2024 at 9:30 AM with the [NAME] President of Operations confirmed the facility did not have documentation that the physician had reviewed Resident 14's Medication Regimen Reviews for 9/24/2023 and 11/15/2023. A record review of a Consultation Report with a recommendation date of 5/24/2023 revealed a recommendation to trial a discontinuation of melatonin for Resident 14. The physician declined the recommendation with rationale of no change. A record review of facility policy Medication Regimen Review, last revised on 8/17/2023, revealed the facility and consultant pharmacist will follow guidance outlined in the CMS State Operations Manual Appendix PP and current practice guidelines, for the appropriate provision of pharmaceutical care.

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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** 29638 Licensure Reference Number 175 NAC 12.006019D Based on record review and interview; the facility failed to ensure that PRN (as needed) orders for psychotropic (any drug capable of affecting the mind, emotions, and behavior) drugs were limited to 14 days or had a stop date or duration documented by the prescriber. In addition, the facility did not have a supporting diagnosis for use of the PRN antipsychotic for 1 (Resident 88) of 5 sampled residents. The facility census was 34. Findings are: A. Review of the facility Antipsychotic Use Policy and Procedure with a revision date of 11/22 revealed the following procedure was to be followed to ensure antipsychotic medications were only used as necessary to treat specific conditions: -prior to requesting medications for the purpose o mood, behavior, or sleep concerns the Interdisciplinary Team was to review non-medical alternatives which had been attempted and to attempt to establish root cause of behaviors. -if alternatives were attempted without success, the physician was to be consulted for medication recommendations after the facility assured appropriate diagnoses/symptoms, monitoring and dose were identified for use. -antipsychotic medications were not to be used for the following symptoms: wandering, poor self-care, restlessness, impaired memory, mild anxiety, nervousness, insomnia, and uncooperativeness. -PRN orders for antipsychotic medications were to be limited to 14 days and were not to be renewed unless the physician evaluated the resident for appropriateness of the medication. -the physician shall respond appropriately by changing or stopping problematic doses or medications or clearly document why the benefits of the medication outweigh the risks. -all residents receiving an antipsychotic medication will have target behaviors monitored daily. Review of Resident 88's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/26/24 revealed the resident was admitted [DATE] with diagnoses of heart failure, insomnia, atrial fibrillation, osteoarthritis, and urinary tract infection in the last 30 days. The resident's cognition was assessed as moderately impaired. The resident had little interest or pleasure in doing things, expressed feeling down, depressed, and hopeless at times, felt tired with little energy and had a poor appetite. In addition, the resident had verbal behaviors which were directed at others which significantly impacted the resident's care. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Medication Administration Record (MAR) dated 4/2024 revealed an order dated 3/19/24 for Seroquel (antipsychotic medication) 25 milligrams (mg) give 0.5 tablet every 24 hours as needed at bedtime for a diagnosis of insomnia. Further review revealed there was no stop date, duration or re-evaluation date identified for use of the Seroquel. During an interview on 4/8/24 at 3:53 PM, the Director of Nursing (DON) confirmed the only diagnosis for use of the PRN Seroquel was insomnia and the facility did not consider this appropriate as a diagnoses for use of an antipsychotic medication. The DON also confirmed the Seroquel was only ordered as a PRN and no stop date or duration date had been identified.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 29638 Licensure Reference Number: 175 NAC 12-006.04D2a Based on record review and interview; the facility failed to ensure the Dietary Manager (DM) had the credentialing to meet the requirements for the position. This had the potential to affect all residents who consumed food from the kitchen. The facility census was 34 with a total sample size of 19. Findings are: Review of the facility Job Description for the role of Dietary Service Director dated 7/1/2018 revealed necessary qualifications included the completion of a Dietary Manager certification course. During an interview on 4/9/24 at 10:08 AM, the [NAME] President of Operations and the facility Administrator confirmed the current Dietary Manager did not have the required training to meet the qualification for the DM position.

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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** 29638 Licensure Reference Number 175 NAC ,d+[DATE].11E Based on observation, record review and interview; the facility staff failed to: 1) utilize handwashing and gloving techniques; and 2) store, prepare and serve food in a manner to prevent the potential for cross contamination and/or food borne illness. These practices had the potential to affect all residents who were served meals from the kitchen. The facility identified a census of 34. Findings are: A. Review of the undated facility policy Date Marking for Food Safety revealed the following regarding the system used to ensure the safety of ready-to-eat food items: -all food to be clearly marked to indicate the date by which the food was to be consumed or discarded. -the individual opening or preparing a food was to be responsible for date marking the food at the time the food was opened or prepared. -the marking system was to consist of the day/date of opening and the day/date the item was to be discarded. -the discard day/date was not to exceed the manufacture's use-by date, or 4 days, whichever was the earliest. The date when food was opened or prepared counted as day 1. -the cook or designee was responsible for checking the refrigerator daily for food items that are expired and were to be discarded accordingly. Review of the undated facility policy Handwashing Guidelines for Dietary Employees revealed handwashing was necessary to prevent the spread of bacteria which could cause foodborne illness. Handwashing was to occur only at the designated handwashing sink and this sink was not to be utilized for purposes other than handwashing. The following guidelines were identified for frequency of handwashing: -after touching bare human body parts other than clean hands and exposed portions of arms. -after handling soiled equipment or utensils. -during food preparation as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. -before putting on gloves and after taking off gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the [DATE] version of the Food Code, based on the United States Food and Drug Administration Food Code and used as an authoritative reference for food service sanitation practices, revealed the following: -,d+[DATE].14 Food employees shall wash hands and exposed portions of their arms immediately before engaging in food preparation: -after handling soiled equipment; and -before donning gloves to work with food. ,d+[DATE].11(C) Packaged Food shall be labeled as specified by law, including 21 CFR 101 Food labeling, 9 CFR 317 Labeling, Marking Devices, and Containers and 9 CFR 381 Subpart Labeling and Containers. -,d+[DATE].13 Nonfood contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue. -,d+[DATE].11(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. -,d+[DATE].11(A) cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (2) Where they are not exposed to splash, dust, or other contamination; and -,d+[DATE].11(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. B. Observations conducted during the initial kitchen tour on [DATE] at 11:01 AM revealed the following prepared, outdated and/or undated food items in the walk-in refrigerator: -pork chops dated [DATE]. -broccoli dated [DATE]. -egg salad dated [DATE]. -ham cubes dated [DATE]. -mandarin oranges which were undated. -mashed potatoes which were undated. Observations also revealed opened bags of chicken breast, chicken patties, chicken strips and French fries in the walk-in freezer which were unlabeled and undated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with the Dietary Manager (DM) on [DATE] at 11:23 AM confirmed all left-over food items were to be labeled and dated according to the date the items had been prepared/served. Any open bags of food in the freezer were to be labeled and dated as to when the bags were first opened. In addition, the facility should have discarded any items which had been stored 4 days or more in the walk-in refrigerator. Observations completed during the follow-up kitchen sanitation tour on [DATE] from 11:00 AM to 12:30 PM revealed the following: -heavy layer of dust particles and grease present on the hood over the stove. -4 drawers which contained various kitchen utensils which were stored in disarray, causing a potential contamination of the food contact surfaces of the utensils. -an opened package of flour tortilla shells stored with kitchen utensils which were undated. -2 containers of opened and undated cornstarch. -2 containers of unopened and undated honey. -4 frying pans which hung from hooks over the food prep area and 2 large cookie sheets with heavy carbon build up and the interior cooking surfaces scratched and worn away making a non-cleanable surface. -ice machine which was used for the residents with a plastic container underneath of the ice dispenser and another large plastic container underneath the front of the unit used for leaking. -cell phone and charger which had been plugged into a wall socket directly above the steam table and was left lying on the top of the steam table while staff prepared food items to be placed into the table. Further observation revealed Dietary [NAME] (DC)-F removed a large pan from the oven which contained a layer of prepared cheese and bacon sandwiches. Without washing hands, using gloves or use of tongs, DC-F placed a cutting board next to the pan with sandwiches. DC-F used bare hands to place individual sandwich onto the cutting board surface and then used a knife to slice the sandwich in half. DC-F continued this process repeatedly before placing sliced sandwiches into a pan and placing into the steam table. During an interview on [DATE] at 10:8 AM the facility Administrator, the DM and the [NAME] President of Operations confirmed the following: -the kitchen staff were to assure food items in the refrigerator and/or freezer were labeled and dated and outdated items then discarded daily. -utensils were to be stored in kitchen drawers so the handles were easily accessed, and the food contact services were not contaminated. -ice machine required maintenance. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-cookie sheets and frying pans were not cleanable in current condition. -staff should not store personal items such as a cell phone on or above food service areas. -dietary cook should not have touched food with bare hands but should have washed hands and used gloves or else used a pair of tongs when working with sandwiches.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 49263 Licensure Reference Number 175 NAC 12-006.07C Based on record review and interview; the facility failed to assure the facility had an effective quality assurance and performance improvement program. This had the potential to affect all residents who resided within the facility. The facility census was 34. The findings are: A record review of a facility provided policy titled QAA (Quality Assurance and Assessment) and QAPI (Quality Assurance and Performance Improvement) Policy and Procedure with a revision date of March 2023 revealed in the Policy Explanation and Compliance Guidelines that the QAA committee was to consist at a minimum of the Director of Nursing (DON), Medical Director (MD), Infection Preventionist (IP), and three other members of the facility staff. The program was to be ongoing, comprehensive and would address the full range of care and services provided by the facility. The policy stated the facility would develop and implement appropriate plans of action to correct identified quality deficiencies and that they would meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects under the QAPI program were necessary. The policy also stated that the facility administration was responsible and accountable for the QAPI program, and that the facility would conduct at least one distinct performance improvement project (PIP) annually that focused on high risk or problem prone areas. An interview on 4/10/24 at 11:32 AM with the Administrator revealed that the QAA committee typically met on a monthly basis and that the IP was not a part of the QAA committee as they worked the night shift. The administrator stated that the DON was aware of all infection control topics and that the DON attended the meetings. The administrator revealed that infection surveillance and antibiotic stewardship were sometimes discussed, and that the committee did discuss topics such as abuse, GDRs (gradual dose reductions), MRR (medication regime reviews), and other topics as they came up. The administrator confirmed that the facility had not conducted any PIPs and that they had not addressed resident weight loss during their meetings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.17 Based on observation, record review, and interview; the facility failed to: 1) utilize the required Personal Protective Equipment (PPE-can include items such as gowns, gloves, masks, goggles, face shields, and foot coverings) when performing wound care for Resident 13 who was on Enhanced Barrier Precautions; 2) complete hand hygiene (hand washing using soap and water or an alcohol based hand rub) and gloving when completing a blood glucose test for Resident 25 and then cleaning/disinfecting the glucose monitor in accordance with manufacturer's recommendations; 3) perform hand hygiene during the distribution of laundry for Residents 5, 8, 9, 12, 14, 15, 19, 25 and 26; and 4) implement measures to prevent the growth of Legionella (severe type of pneumonia/lung infection caused by bacteria which can be found in water) and/or waterborne pathogens in the facility. These practices had the potential to affect all facility residents. The total sample size was 19 and the census was 34. Findings are: A. Review of Resident 13's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/14/24 revealed the resident was admitted [DATE] with diagnoses of dementia, history of Transient Ischemic Attack (TIA-temporary disruption of blood supply to part of the brain with stroke like symptoms lasting only a short time), hemiplegia (paralysis on 1 side of the body) and pressure ulcer to the left hip. The resident was assessed as cognitively intact and as having an unstageable (staging system is a method of summarizing characteristics of pressure ulcers including the extent of tissue damage. Unstageable is a full thickness tissue loss in which the base of the ulcer is covered by dead tissue which may be brown, black, or tan in color) pressure ulcer when admitted to the facility. Observation on 4/7/24 at 2:13 PM revealed Resident 13 was in the resident's room and positioned in a wheelchair. Directly outside of the resident's room in the corridor, was a 3-drawer plastic storage unit which contained disposable gowns, gloves, and surgical masks. In addition, a large container of hand sanitizer was located on top of the unit. Further observations revealed no signs or information had been posted outside the resident's room to indicate why the storage unit with PPE was available outside of the resident's room. Observations of Resident 13 on 4/8/24 revealed the following: -7:00 AM the plastic storage unit with PPE remained outside of Resident 13's room. No signs or information was posted to indicate why the PPE was stored outside of the resident's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-10:38 AM Registered Nurse (RN)-I entered the resident's room to complete a dressing change to the resident's unstageable pressure ulcer to the left hip. RN-I washed hands and put on clean disposable gloves in the resident's bathroom and proceeded to complete the dressing change. RN-I failed to place on a clean disposable gown, gloves, and surgical mask from the container outside of the resident's room. During an interview on 4/8/24 at 10:46 AM, RN-I verified placement of the PPE outside of the resident's room but identified no knowledge regarding use of the additional PPE. RN-I revealed no signs had been posted to identify the resident was on any type of precautions and nothing had been reported to RN-I. During an interview on 4/8/24 at 2:32 PM, Medication Aide (MA)-A and Nurse Aide (NA)-C revealed the direct care staff had been instructed by the Director of Nursing (DON) about a week ago to wear a gown, gloves and a mask when performing direct cares for Resident 13 as the resident was on enhanced barrier precautions due to the resident's pressure ulcer. During an observation on 4/9/24 at 7:00 AM, a sign was posted outside of Resident 13's room which indicated the resident was on enhanced barrier precautions. The sign indicated everyone was to clean hands before entering the room and when exiting the room. In addition, providers and staff were to wear gloves, mask and a gown in the resident's room when assisting with dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or with toileting, device care or use (central line, urinary catheter, feeding tube or tracheostomy) and when providing wound care. Interview with the [NAME] President of Operations (VPO)-H on 4/9/24 at 10:18 AM, revealed RN-I should have worn a face mask, gown and gloves when completing Resident 13's wound care on 4/8/24 at 10:38 AM. In addition, the facility should have had signs posted outside of the resident's room to ensure all staff were aware the resident was on enhanced barrier precautions. B. Review of the facility policy Handwashing/Hand Hygiene with a revision date of 1/2020 revealed the following regarding hand hygiene: -All personnel would be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of health care associated infections. -All personnel would follow the handwashing/hand-hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. -Hand Hygiene products and supplies (sinks, soap, towels, alcohol-based hand rub etc.) would be readily accessible and convenient for staff use, to encourage compliance with hand hygiene policies. -Staff would wash hands with soap and water for the following situations when hands were visibly soiled and after contact with residents with infectious diarrhea. -Staff would use alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285091	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2024
NAME OF PROVIDER OR SUPPLIER Indian Hills Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 1720 North Spruce Ogallala, NE 69153	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-before and after direct contact with residents. -before preparing or handling medications. -before putting on gloves. -before moving from a contaminated body site to a clean body site during resident care. -after contact with a resident's intact skin. -after contact with a resident's body of bodily fluids. -after contact with objects or medical equipment in the immediate vicinity of the resident. -after removing gloves. -before and after entering isolation settings. -before and after eating or handling food, -before and after assisting a resident with meals. -after personal use of the toilet or conducting personal hygiene. B. Review of the facility policy Glove Use with a revision date of 1/2019 revealed when gloves were indicated, staff were to wear disposable single use gloves. The following was identified as to when gloves were to be worn: -when touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin. -when the employee's hands contain scrapes, any cuts, wounds, or chapped skin. -when cleaning up spills or splashes of blood or body fluids. -when handling potentially contaminated items and when it is likely that hands would encounter blood, body fluids or other potentially infectious material. -when performing a blood draw or starting/discontinuing Intravenous (IV) therapy. Review of the facility Blood Glucose Monitor Use and Disinfection Policy with a revision date of 1/2022 the following procedure for cleaning/disinfection of a blood glucose monitor: -gather equipment; blood glucose machine and testing strip, EPA registered wipes, lancets, sharps container, towel/paper towel and gloves. -place equipment on a towel or a paper towel barrier between the table and the equipment. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-wash hands and place on gloves. -after performing the glucose test, throw the used lancet and the testing strip into a sharp's container. -clean all external parts of the monitor with and EPA registered disinfectant wipe and then discard wipe. -disinfect the monitor by continuously wiping or wrapping the monitor with a second wipe to ensure contact time of one minute. -place the monitor on another barrier. -remove gloves and perform hand hygiene. -place the glucometer back into the medication cart or other clean storage area. During observations of blood glucose testing performed by Medication Aide (MA)-B on 4/8/24 at 8:55 AM the following was observed: -opened the top drawer of the medication cart and removed a zippered pouch. Without benefit of a barrier, removed a blood glucose monitor and testing supplies from the pouch and placed directly on the top of the contaminated surface of the mediation cart. -carried the blood glucose machine and supplies to Resident 25's dining room table and without placing a barrier, positioned the machine and supplies directly on the table next to the resident's breakfast meal, drinks, utensils and a soiled napkin. -without performing hand hygiene or placing on disposable gloves, MA-B obtained a drop of blood and proceeded with the glucose test. -MA-B then carried the glucometer from the dining table and placed directly on the top of the medication cart still without benefit of a barrier. -MA-B without performing hand hygiene, opened a drawer on the cart and returned the blood glucose machine to the zippered pouch without cleaning/disinfecting the machine. During an interview on 4/9/24 at 9:56 AM, the VPO-H confirmed the following: -MA-B should have placed the blood glucose monitor and testing supplies on a barrier before placing on the contaminated surface of the medication cart and the dining table. -MA-B should have performed hand hygiene and worn gloves before completing the blood glucose testing. MA-B should have then removed gloves and performed hand hygiene again when testing was completed. -MA-B should have cleaned/disinfected the blood glucose monitor before returning to the storage pouch and placing into a drawer on the medication cart. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	49263 C. A record review of a facility provided policy titled Handwashing/Hygiene with a revision date of January 2020 revealed that hand hygiene needed to be completed after contact with objects in the resident's room. An observation on 4/8/24 from 12:06 PM until 12:12 PM of Laundry Aide (LA)-J revealed LA-J delivered residents' personal laundry to resident rooms 35, 36, 43, 44, and 42, opening resident dresser drawers and closet doors in each room while putting away the clean laundry. LA-J also removed empty hangers from rooms 36, 43, 44, and 42 and hung them on the outside of the clean laundry cart. LA-J did not perform hand hygiene at any time during this process. An interview on 4/9/24 at 12:57 PM with LA-J confirmed that LA-J did not perform hand hygiene at all while delivering the residents' personal laundry to the resident rooms on 4/8/24. D. A record review of a facility provided policy titled Legionella Surveillance Policy with a revision date of October 2022 revealed Legionella prevention strategies that included conducting a full-scale environmental investigation to identify environmental sources and decontamination of identified environmental sources in accordance with current standards. An interview on 4/10/24 at 8:10 AM with the Administrator confirmed that the facility had not conducted a water risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread. The administrator stated that they did run water in the empty rooms on occasion but could not provide a frequency and confirmed this procedure was not documented. The administrator confirmed the facility had not developed or implemented a plan to prevent the growth of Legionella and other opportunistic waterborne pathogens in the facility's water systems.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 49766 Licensure Reference 175 NAC 12-006.04B2a Based on interviews and record review; the facility failed to ensure 4 Nursing Assistants (NA) (NA-M, NA-N, NA-O, NA-P) had at least 12 hours of continuing education in 2023, including Dementia and infection control training of 5 staff reviewed. The facility identified a census of 34. The findings are: A record review of staff education records revealed the following: - NA-M had a total of 0.5 hours of continuing education for 2023 and did not have Dementia or infection control training - NA-N had a total of 4.25 hours of continuing education for 2023 and did not have Dementia training - NA-O had a total of 7.10 hours of continuing education for 2023 - NA-P had a total of 5.15 hours of 12 hours of continuing education for 2023 An interview on 4/8/2024 at 4:07 PM with the Administrator confirmed the staff did not have the required continuing education. A record review of a facility policy Staff Training, Retention of Records, Including CNA, Programing Policy and Procedure with an effective date of October 2022, revealed the facility will complay with State and Federal regulation and requirements for continuing education of its nurses aides. Minimum facility training included Dementia, infection control, and abuse/neglect training.