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	03/04/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. 51122 Licensure Reference 175 NAC 12-006.17 Based on observation, interview, and record review, the facility failed to protect the private health information of 3 (Residents 9, 23, and 32) of 4 sampled residents. The facility identified a census of 27. Findings are: A continuous observation on 2/27/25 from 7:26 AM to 8:00 AM revealed Registered Nurse (RN-J) administering medications in the dining room using a laptop computer mounted on a mobile medication cart. The observation revealed RN-J preparing medications for Resident 32. RN-J took the prepared medications to Resident 32's table, leaving the computer screen open with Resident 32's private health information visible while they walked to the resident and administered the medications. RN-J then returned to the medication cart, marked the medications as administered in the computer and proceeded to the next resident. The observation revealed RN-J preparing medications for Resident 9. RN-J took the prepared medications to Resident 9's table, leaving the computer screen open with Resident 9's private health information visible while they walked to the resident and administered the medications. RN-J then returned to the medication cart, marked the medications as administered in the computer and proceeded to the next resident. The observation revealed RN-J preparing medications for Resident 23. RN-J took the prepared medications to Resident 23's table, leaving the computer screen open with Resident 23's private health information visible while they walked to the resident and administered the medications. RN-J then returned to the medication cart and documented the medications. A record review of a facility document titled, HIPAA health insurance portability and accountability act; privacy policies and procedures, dated 8/1/18, revealed the following statement, It is the policy of Facility to protect the privacy of individual health information and to ensure that such information is used and disclosed appropriately and in accordance with all applicable laws and regulations. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of a facility document titled, Resident rights policy, last revised November 2019, revealed the following statement, The resident has a right to personal privacy and confidentiality of his or her personal and medical records. The policy also revealed the resident has a right to secure and confidential personal and medical records. An interview on 2/27/25 at 8:00 AM with RN-J confirmed they did leave the computer screen open with the private health information of Residents 9, 23, and 32 visible to anyone in the vicinity of the cart while they were performing medication administration in the dining room and this shouldn't have happened. RN-J also confirmed this was their usual routine.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 49766 Licensure Reference 175 NAC 12-006.09(D) Based on record reviews and interviews, the facility failed to ensure the Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) accurately reflected active diagnoses for 1 (Resident 3) of 12 sampled residents. The facility identified a census of 27. Findings are: A record review of a facility policy, MDS Policy with a revision date of March 2019 revealed a the purpose of the policy was to ensure the timeliness and accuracy of all MDS' by ensuring the facility staff followed the guidelines laid out in the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities.) A record review of the RAI Manual with an effective date of 10/1/2023 revealed the following in regarding to Section I: Active Diagnoses under steps for assessment: - Identify which diagnoses are active, noting that active diagnoses are diagnoses that have a direct relationship to the resident's current functional, cognitive, or mood or behavior status, medical treatments, nursing monitoring, or risk of death during the 7-day look-back period. - Do not include conditions that have been resolved, do not affect the resident's current status, or do not drive the resident's plan of care during the 7-day look-back period, as these would be considered inactive diagnoses. A record review of an Admission Record indicated the facility admitted Resident 3 on 1/11/2022 with a diagnosis of Dementia (a progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior.) A record review of Resident 3's Medical Diagnosis List as of 2/27/2025 revealed the following: - A diagnosis of a trochanteric fracture (break) of the femur (thigh bone) with a date of 3/6/2023 and without a resolved date. - A diagnosis of the sixth cervical (neck) vertebra fracture with a of 1/11/2022 and without a resolved date. - A diagnosis of the seventh cervical vertebra fracture with a date of 1/11/2022 and without a resolved date. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 3's quarterly MDS with an an Assessment Reference Date (ARD) of 7/22/2024 revealed Hip fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck) and Other Fracture listed under the Active Diagnoses section. A record review of Resident 3's quarterly MDS with an ARD of 10/22/2024 revealed Hip fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck) and Other Fracture listed under the Active Diagnoses section. A record review of Resident 3's annual MDS with an ARD of 1/20/2025 revealed Hip fracture - any hip fracture that has a relationship to current status, treatments, monitoring (e.g., sub-capital fractures, and fractures of the trochanter and femoral neck) and Other Fracture listed under the Active Diagnoses section. A record review of Resident 3's medical chart from 7/1/2024 through 2/27/2025 revealed no evidence of current fractures that had a direct effect on Resident 3's current health status, ongoing treatments, or ongoing monitoring. An interview on 3/3/2025 at 12:30 PM with the Assistant Director of Nursing (ADON) confirmed Resident 3's fractures had resolved well over a year ago. An interview on 3/3/2025 at 3:00 PM with the MDS Nurse confirmed Resident 3's MDS' from 7/22/2024, 10/22/2024, and 1/20/2025 were coded incorrectly as active hip fracture and should have been coded as having a history of these fractures.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51560 Licensure Reference Number 175 NAC 12-006.09(F)(i) Based on interview and record review the facility failed to develop and implement a baseline care plan within 48 hours of admission for 3 (Resident 35, 27, and 23) of 4 sampled residents. The facility identified a census of 27. The findings are: A record review of a Baseline Care Plan Policy dated 4/23/2019 revealed the baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident including but not limited to: i. Initial goals based on admission orders ii. Physician orders iii. Dietary orders iv. Therapy services v. Social Services vi. PASARR recommendations, if applicable. A. A record review of an admission face sheet for Resident 35 revealed an admitted [DATE]. Resident 35 was admitted to the facility for Palliative Care (care that is focused on symptom control, pain relief, and quality of life). A record review of an admission facesheet for Resident 35 revealed the following pertinent diagnoses: 1. Atrial Fibrillation- a common heart rhythm disorder where the upper chambers of the heart (atria) beat irregularly and rapidly. 2. Osteomyelitis- an infection of the bone that causes inflammation and destruction of bone tissue. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Neuralgia and Neuritis- severe, sharp, or burning pain that follows the path of a specific nerve and inflammation of the nerve. A record review of a Care Plan for Resident 35 revealed a focus area of Resident 35 being admitted to facility for comfort cares with an initiation date of 1/30/25. An advanced directives focus area was initiated on 1/30/25. An emergency and evacuation preference focus area was initiated on 1/30/25. Focus areas including mobility, diet/nutrition, pain, catheter, skin, and mood were noted to have an initiation date of 2/2/25. An interview with the Social Services Director (SSD) on 3/3/25 at 3:45 PM revealed the process for developing the care plan involves all departments inputting the data pertaining to their own department. This process begins on the day of admission. The SSD stated the facility does not incorporate the use of a separate baseline care plan while developing the comprehensive care plan. The SSD confirmed that a baseline care plan was being developed as part of the comprehensive care plan and had not been developed to include mobility, diet/nutrition, pain, catheter, or skin focus areas as required in the regulatory time frame. An interview with the Director of Nursing (DON) on 3/3/25 at 4:00 PM revealed that the nursing portion is electronically pulled to the care plan based off of the admission assessments that are performed by floor nurses the day of admission. If those assessments are late or are not locked, they do not pull over in time. The DON confirmed that the facility does not utilize a baseline care plan separately from the comprehensive care plan. The DON confirmed that the Nursing Departments' portion of the care plan was not initiated until 2/2/25. 51122 B. Record review of Resident 23's medical record revealed that Resident 23 was admitted on [DATE] with a primary diagnosis of diabetes type 2. A record review of Resident 23's care plan (including revision history in the electronic medical record) revealed the earliest entry was made on 2/11/25. An interview on 3/3/25 at 1:45 PM with the Registered Nurse Clinical Coordinator (RN-CC) revealed that the facility used Point Click Care (healthcare technology platform) for the care plans from the day of admission, and that there was not any other paper or electronic care plan used during a resident's first 48 hours in the facility. An interview on 3/4/25 at 11:59 AM with Director of Nursing (DON) confirmed there was not a baseline care plan for Resident 23 and there should have been. C. A record review of Resident 27's medical record revealed that Resident 27 was admitted on [DATE] with diagnoses of dementia (group of symptoms affecting memory, thinking and social abilities) and a femur (thigh bone) fracture. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 27's care plan revealed the earliest entry was made on 10/1/24. An interview on 3/4/25 at 11:59 AM with the DON confirmed there was not a baseline care plan for Resident 27 and there should have been.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 49766 Licensure Reference 175 NAC 12-006.09(H)(i)(3) Based on record reviews and interviews, the facility failed to provide bathing services during isolation precautions for 1 (Resident 3) of 1 sampled resident. The facility identified a census of 27. Findings are: A record review of a facility policy, ADL Assistance Provided Per Care Plan with a revised date of 9/2022 revealed bathing and showering would be provided as needed based upon the resident's desires, assessment, care plan, and ADL (Activities of Daily Living) assistance deemed necessary. A record review of an Admission Record indicated the facility admitted Resident 3 on 1/11/2022 with a diagnosis of Dementia (a progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior.) A record review of Resident 3's annual Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) with an Assessment Reference Date of 1/20/2025 revealed Resident 3 had severe cognitive impairment. The MDS also revealed Resident 3 was dependent for bathing. A record review of Resident 3's Care Plan revealed on 1/11/2022 a focus area revealing Resident 3 needed assistance with bathing was initiated. A revised intervention on 2/26/2023 revealed Resident 3 needed extensive assistance with bathing. A record review of Resident 3's Progress Note from 2/10/2025 revealed Resident 3 had tested positive for Influenza A and was placed into isolation precautions. A record review of Resident 3's POC Response History (a document that provides a history of documentation from the past 30 days) with a date of 2/27/2025 revealed Resident 3 had a documented bath on 1/29/2025, 2/19/2025, and 2/23/2025. A record review of a Weekly Bath Sheet for the week of 2/2/2025-2/8/2025 revealed on 2/2/2025 and 2/5/2025 that Resident 3 received a bath. A record review of a Weekly Bath Sheet for the week of 2/9/2025-2/15/2025 revealed on 2/9/2025 and 2/12/2025 Resident 3 was marked as in isolation and no bath was given. A record review of a Weekly Bath Sheet for the week of 2/16/2025-2/22/2025 revealed on 2/16/2025 that Resident 3 was marked as in isolation and no bath was given. An interview on 2/27/2025 at 10:35 AM with Nurse Aide (NA) - B revealed the baths are documented on the weekly bath sheets and then later charted in the Electronic Health Record (EHR.) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/3/2025 at 10:25 AM with NA-A revealed staff had been instructed not to give residents who were in isolations baths to limit the spread of influenza. NA-A also revealed staff could offer bed baths to residents in isolation which would have been documented on the Weekly Bath Sheets then in the EHR if it had been completed. An interview on 3/3/2025 at 12:30 PM with the Assistant Director of Nursing (ADON) confirmed Resident 3 had not received a bath from 2/5/2025 until 2/19/2025 or for two weeks while they were in isolation. But should have been given a bath after the residents who were not in isolation or offered a bed bath.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51560 Licensure Reference 175 NAC 12-006.09(H)(vi)(3)(g) Based on interview and record review the facility failed to ensure that monitoring during the course of their acute illness was documented for 3 (Resident 3, 8, and 18) of 3 sampled residents . The facility identified a census of 27. The findings are: A record review of a Change of Condition Policy dated 3/2019 revealed on page 4 (B.)- The Nurse will record information relative to changes in the residents condition or status in the resident's medical record. The residents' condition is assessed and reported in a timely manner either verbally or written if the resident experiences signs and symptoms of infection. A. A record review of Resident 18's admission face sheet revealed an admitted [DATE]. A record review of Resident 18's pertinent diagnoses include: 1. Unspecified dementia (a condition where cognitive decline and memory loss occur, but the specific underlying cause cannot be determined). 2. Ventricular Tachycardia (a fast, abnormal heart rhythm). 3. Cardiomyopathy (disorder that affects the heart muscles ability to pump effectively). A record review of a quarterly Minimum Data Set (MDS-a standardized assessment of the health of residents in nursing homes) dated 1/3/25 revealed in Section C, a Brief Interview for Mental Status (BIMS- a screening tool that assesses a person's cognitive impairment on a score of 0/15) score of 9/15, indicating that Resident 18 had moderate cognitive impairment. Section GG indicated that Resident 18 used a walker for ambulation and received stand-by or touching assistance from staff for dressing, undressing, hygiene, and toileting. A record review of Resident 18's current physician orders revealed an order for Doxycycline (an antibiotic) 100 milligrams (mg) by mouth twice a day for seven days related to a recent diagnosis of pneumonia (an infection of the lungs that causes inflammation of the air sacs). A record review of an Admission Note dated 2/24/25 revealed Resident 18 had returned to the facility after a hospital admission. The nursing note revealed Resident 18 was transported to the hospital via Resident 18's daughter over the weekend due to Resident 18 having a recent diagnosis of influenza A (a type of respiratory virus) and not recovering well. Resident 18 was diagnosed with pneumonia and was admitted to the hospital for treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of nursing notes prior to 2/24/25 revealed no documented evidence of Resident 18's transfer to the hospital. There was no documented evidence of a nursing assessment or decision to send Resident 18 for emergent evaluation and treatment. An interview on 2/26/25 at 2:30 PM with the DON revealed that the expectation of the nurse when a change in condition occurs is to do a full assessment of the resident including vital signs and a neurological assessment. That information is to be charted as a nurses note. The nurse is then to call the provider and family with the results of the assessment. The nurse should receive and document any new orders. The DON confirmed there was no documentation regarding Resident 18's transfer to the hospital or their condition or assessment prior to transferrring to the hospital. The DON confirmed that there should have been documentation of Resident 18's condition, results of Resident 18's assessment, and subsequent transfer to the hospital. 49766 B. A record review of an Admission Record indicated the facility admitted Resident 3 on 1/11/2022 with a diagnosis of Dementia and Chronic Obstructive Pulmonary Disease (an ongoing lung condition caused by damage to the lungs that can cause airflow obstruction and breathing difficulties.) A record review of Resident 3's Care Plan revealed that on 2/19/2025 a care focus area for Resident 3 having Influenza A was initiated. Interventions listed were to encourage fluid intake and monitor and document for signs of dehydration, such as poor skin turgor, dry mucous membranes, slowed capillary refill, increased heart rate, cool dry skin, sunken eyeballs, decreased urinary output, difficulty breathing, or low blood pressure. A record review of Resident 3's Progress Notes from 2/10/2025-2/28/2025 revealed the following: - On 2/10/2025 at 7:06 AM, it was noted that Resident 3 had been up most of the night, hollering out they did not feel good, but was unable to give a description. Resident 3 was noted to have a non-productive cough and congestion without fever. Resident 3 was test for Influenza A at 4:30 AM and tested positive. Resident 3's physician was notified by fax of these results. - There was no evidence of further documentation or assessment between 2/10/2025 and 2/14/2025. - On 2/14/2025 at 9:42 PM, it was noted that Resident 3 continued to have a non-productive cough and congestion, in addition to a sore throat and fatigue. It was also noted that Resident 3 was lethargic (a decrease in consciousness,) pallor (pale skin,) and expiratory wheezing. Oxygen saturation was noted to be 92% without oxygen supplementation, no fever, and normal respirations. The head of bed was raised and fluids were encouraged. There was no evidence that the physician had been notified of Resident 3's condition. - There was no evidence of further documentation or assessment between 2/14/2025 and 2/18/2025. - On 2/18/2025 at 3:52 PM, Resident 3's physician was there to do a monthly medication review and found resident to continue to have wheezing. The physician prescribed a nebulizer treatment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was no evidence of further documentation or assessment after 2/18/2025. A record review of Resident 3's Vitals Summary from 2/10/2025-2/28/2025 revealed the following: - Resident 3's temperature was checked on 2/13/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/18/2025, and 2/23/2025. Resident 3 had a fever on 2/14/2025 and all other temperatures were within normal limits. - Resident 3's respirations were measured on 2/16/2025 and 2/23/2025. Both were within normal range. - Resident 3's oxygen saturation was measured on 2/13/2025, 2/14/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/18/2025 at 9:45 AM, 2/18/2025 at 9:32 PM, and 2/23/2025. All oxygen saturations were within normal limits, except on 2/14/2025 with a low oxygen saturation of 89% without oxygen supplementation. - Resident 3's blood pressure was measured on 2/16/2025 and 2/23/2025. Both were within normal ranges. An interview on 3/3/2025 at 12:30 PM with the Director of Nursing (DON) revealed during acute illnesses like Influenza A, residents should be monitored through a full assessment with vital signs at least once a shift. The DON confirmed Resident 3 had not been monitored every shift during their acute illness and should have been. C. A record review of an Admission Record indicated the facility admitted Resident 8 on 12/19/2028 with Congestive Heart Failure (a chronic condition where the heart muscle is weakened and cannot pump blood efficiently,) diabetes, and vascular dementia. A record review of Resident 8's Progress Notes from 2/10/2025-2/28/2025 revealed the following: - On 2/10/2025 at 6:21 AM, it was noted that Resident 8 had complaints of a headache and sinus pressure. Resident 8 also had a non-productive cough and no fever. A test for Infleunza A was performed at 4:50 AM and was positive. Resident 9's physician was notified by fax of these results. - There was no evidence of further documentation or assessment between 2/10/2025 and 2/16/2025. - On 2/16/2025 at 1:59 AM, it was noted that Resident 8 continued to have a non-productive cough, in addition to a sore throat and fatigue. Resident 8 had no fever and oxygen saturation was within normal ranges. Resident 8 reported feeling better. - There was no evidence of further documentation or assessment between 2/16/2025 and 2/18/2025. - On 2/18/2025 at 4:06 PM, Resident 8 was seen by their physician for a monthly medication review. Resident 8 continued to have non-productive cough and was prescribed guaifenesin (a medication used to help clear mucus from the chest.) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- There was no evidence of further documentation or assessment after 2/18/2025. A record review of Resident 8's Vitals Summary from 2/10/2025-2/28/2025 revealed the following: - Resident 8's temperature was monitored on 2/13/2025, 2/14/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/18/2025, and 2/23/2025 and all were within normal range. - Resident 8's respirations were monitored on 2/16/2025 and 2/23/2025 and were found to be 20 breaths per minute. - Resident 8's pulse was monitored on 2/16/2025 and 2/23/2025 and were within normal range. - Resident 8's oxygen saturation was monitored on 2/13/2025, 2/14/2025, 2/15/2025, 2/16/2025, 2/17/2025, 2/18/2025, and 2/23/2025 and all were within normal range. An interview on 3/3/2025 at 12:35 PM with the DON revealed during acute illnesses like Influenza A, residents should be monitored through a full assessment with vital signs at least once a shift. The DON confirmed Resident 8 had not been monitored every shift during their acute illness and should have been.

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	285091	A. Building B. Wing	03/04/2025

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 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. 49766 Licensure Reference 175 NAC 12-006.04(B)(ii)(1) Based on record reviews and interviews, the facility failed to ensure that 4 of 5 sampled employees had completed at least 12 hours of ongoing training for the year as required. This had the potential to affect all residents who reside within the facility. The facility identified a census of 27. Findings are: A record review the facility's Facility Assessment Tool with a date of 2/26/2025 revealed all training will be completed at least upon orientation, annually, and as needed of at least 12 hours per year. Topics of training included dementia, abuse/neglect, effective communication, resident's rights, infection control, culture changes, and orthopedic special care. A record review of an undated staff list provided by the facility revealed the following: - Medication Aide (MA) - D was hired on 8/19/2010. - Nurse Aide (NA) - A was hired on 7/1/2022. - MA-G was hired on 4/21/2013. - MA-F was hired on 5/3/2022. A record review of MA-D's Training Hours from 8/19/2023-8/19/2024 revealed MA-D had a total of 0.5 hours of ongoing training. MA-D had 0 hours of ongoing training on dementia or abuse/neglect. A record review of NA-A's Training Hours from 7/1/2023-7/1/2024 revealed a total of 4.95 hours of ongoing training. Additional record review revealed NA-G had completed duplicate courses of Teepa Snow(Dementia training): Dementia 101 for 0.25 hours. Therefore, NA-G had completed a total of 4.7 hours of ongoing training. A record review of MA-G's Training Hours from 4/21/2023-4/21/2024 revealed MA-G had a total of 9 hours of ongoing training. A record review of MA-F's Training Hours from 5/3/2023-5/3/2024 revealed MA-F revealed a total of 15.7 hours of ongoing training. Additional record review revealed MA-F had completed duplicate courses of Dementia Care, Hazardous Chemicals, Preventing/Managing Accidents, Safe Patient Handling, and Tuberculosis Basics for a total of 4 duplicate hours. Therefore, MA-F had completed a total of 11.7 hours of ongoing training. An interview on 3/3/2025 at 1:45 PM with the Administrator confirmed NA-A and MA-F had completed duplicate courses and MA-D had not completed training for the year on dementia or abuse/neglect for the year. The Administrator also confirmed MA-D, NA-A, MA-G, and MA-F had not completed at least 12 hours of ongoing training for the year as required.

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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** 51122 Licensure Reference 12-006.18 Licensure Reference 12-006.09 (D)2 Based on observations, record review, and interview, the facility failed to implement a water management program as required to monitor and prevent the potential for legionella and other waterborne pathogens. This had the potential to affect all residents that resided within the facility. The facility also failed to perform hand hygiene as required during wound care for 1 (Resident 2) of 1 sampled resident. The facility identified a census of 27. Findings are: A. A record review of a facility policy titled, Water system management program prevention plan for legionella, and dated 2022, revealed in the policy explanation and compliance guidelines section: 2. The maintenance director maintains documentation that describes the facility's water system. 6. Control measures will be applied to address potential hazards at each control point. The measures shall be specified in the water management program action plan. The Sample Water System Surveillance QAA Action Plan section revealed the following: Control point/program area Unoccupied unit, The control measure/action needed was to perform twice weekly flushing of sinks and fixtures with hot and cold water. Control point/program area eyewash station, the control measure/action needed was to run water for 5 minutes weekly. Record review of a facility document titled, Water System Infection Control Risk Assessment, dated 6/6/24, revealed several risk factors/threats of manual faucets, showerheads and hoses, and 4 eyewash stations. Record review of a facility document titled, Water testing and flushing, dated 12/31/24 revealed the chlorine level in 4 tested eyewash stations and selected resident rooms was 0. Each of these rooms was documented as flushed. Record review of a facility document titled, Water testing and flushing, dated 1/7/25 revealed the chlorine level in 4 tested eyewash stations and selected resident rooms was 0. Each of these rooms was documented as flushed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of a facility document titled, Water testing and flushing, dated 2/19/25 revealed the chlorine level in 4 tested eyewash stations and selected resident rooms was 0. Each of these rooms was documented as flushed. An interview with the Nursing Home Administrator (NHA) on 3/4/25 at 9:53 AM confirmed the facility did not have a description of the facility's water systems, and that the facility chlorine levels were tested on [DATE], 1/7/25, and 2/19/25, and found to be zero. The NHA also confirmed the same eyewash stations and randomly selected resident rooms' sinks and toilets were flushed on the three listed dates. There were no additional dates those tasks were performed during the time period. B. Record review of Resident 2's admission record revealed they were admitted on [DATE]. Record review of Resident 2's physician orders revealed an order dated 1/8/25 to perform wound care on Resident 2's right gluteal fold daily. An observation on 3/3/25 at 10:47 AM revealed Licensed Practical Nurse -K (LPN-K) removed the soiled dressing from Resident 2's right buttock area, then removed their gloves. LPN-K put clean gloves on, then put a new dressing onto Resident 2's right buttock. Record review of a facility policy titled, Dressing Clean/Aseptic, last revised in March 2019, revealed that after gloves are removed following the removal of a soiled wound dressing, hand hygiene is necessary (with soap and water or alcohol-based hand sanitizer) prior to putting on new gloves. An Interview on 3/3/25 at 11:08AM with LPN-K confirmed they did not perform hand hygiene after removing a dirty dressing and before applying clean gloves and putting on new dressing.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. 49766 Licensure Reference 175 NAC 12-006.04(B)(i) Based on record reviews and interview, the facility failed to ensure 5 of 5 sampled employees had completed initial orientation training within 2 weeks after beginning employment that included resident rights and emergency procedures as required. This had the potential to affect all residents who resident within the facility. The facility identified a census of 27. Findings are: A record review the facility's Facility Assessment Tool with a date of 2/26/2025 revealed training will be completed at orientation, annually, and as needed. Trainings will include effective communication, resident right's abuse/neglect, infection control, and culture change. A record review of an undated staff list provided by the facility revealed the following: - Cook-H was hired on 11/7/2024. - Dietary Aide (DA) - I was hired on 1/7/2025. - The Director of Nursing (DON) was hired on 2/16/2025. - Nurse Aide (NA) - B was hired on 1/6/2025. - NA-C was hired on 12/2/2024. A record review of Cook-H's personnel file documents provided by the facility revealed no evidence initial orientation training had been completed. A record review of DA-I's personnel file documents provided by the facility revealed no evidence initial orientation training had been completed. A record review of the DON's Training Hours dated 3/3/2025 revealed no evidence initial orientation training regarding resident rights and emergency procedures had been completed. A record review of NA-B's Training Hours dated 3/3/2025 revealed no evidence initial orientation training regarding resident rights and emergency procedures had been completed. A record review of NA-C's Training Hours dated 3/3/2025 revealed no evidence initial orientation training regarding resident rights and emergency procedures had been completed. An interview on 3/3/2025 at 4:20 PM with the Administrator confirmed no initial orientation had been completed by Cook-H or DA-I and no initial orientation on resident rights or emergency procedures had been completed by the DON, NA-B, or NA-C within two weeks of hire as required.

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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 12-006.04(B)(ii)(1) Based on record reviews and interviews, the facility failed to ensure that 4 of 5 sampled employees had completed at least 12 hours of ongoing training in the year which included dementia management training and resident abuse prevention training. This had the potential to affect all residents who reside within the facility. The facility identified a census of 27. Findings are: A record review the facility's Facility Assessment Tool with a date of 2/26/2025 revealed all training will be completed at least upon orientation, annually, and as needed of at least 12 hours per year. Topics of training included dementia, abuse/neglect, effective communication, resident's rights, infection control, culture changes, and orthopedic special care. A record review of an undated staff list provided by the facility revealed the following: - Medication Aide (MA) - D was hired on 8/19/2010. - Nurse Aide (NA) - A was hired on 7/1/2022. - MA-G was hired on 4/21/2013. - MA-F was hired on 5/3/2022. A record review of MA-D's Training Hours from 8/19/2023-8/19/2024 revealed MA-D had a total of 0.5 hours of ongoing training. MA-D had 0 hours of ongoing training on dementia or abuse/neglect. A record review of NA-A's Training Hours from 7/1/2023-7/1/2024 revealed a total of 4.95 hours of ongoing training. Additional record review revealed NA-G had completed duplicate courses of Teepa Snow(Dementia training): Dementia 101 for 0.25 hours. Therefore, NA-G had completed a total of 4.7 hours of ongoing training. A record review of MA-G's Training Hours from 4/21/2023-4/21/2024 revealed MA-G had a total of 9 hours of ongoing training. A record review of MA-F's Training Hours from 5/3/2023-5/3/2024 revealed MA-F revealed a total of 15.7 hours of ongoing training. Additional record review revealed MA-F had completed duplicate courses of Dementia Care, Hazardous Chemicals, Preventing/Managing Accidents, Safe Patient Handling, and Tuberculosis Basics for a total of 4 duplicate hours. Therefore, MA-F had completed a total of 11.7 hours of ongoing training. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 3/3/2025 at 1:45 PM with the Administrator confirmed NA-A and MA-F had completed duplicate courses and MA-D had not completed training for the year on dementia or abuse/neglect for the year. The Administrator also confirmed MA-D, NA-A, MA-G, and MA-F had not completed at least 12 hours of ongoing training for the year as required.