STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285092	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emerald Nursing & Rehab Columbus	2855 40th Avenue Columbus, NE 68601

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number: 175 NAC 12-006.09(H)(iii)(2) Based on observation, record review and interview; the facility failed to follow practitioner's orders regarding a dressing change for 1 (Resident 2) of 5 sampled residents. The facility census was 79. Findings are: Review of Resident 2's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 7/10/24 revealed the resident was admitted [DATE] with diagnoses of anemia, high blood pressure, diabetes, anxiety, manic depression, and chronic obstructive pulmonary disease. The following was assessed regarding Resident 2: -short- and long-term memory loss with severely impaired decision-making skills, -required total assistance with bed mobility, transfers, dressing, personal hygiene, and toilet use, -feeding tube which provided 51 percent (%) or more of total calories and 501 cubic centimeters (cc) per day or more of average fluid intake, and -had two unhealed stage 3 pressure ulcers (full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss) on admission. Review of the resident's current Care Plan dated 7/4/24 revealed the resident had actual impairment of skin integrity to the resident's coccyx and bilateral heels as the resident had been bedridden for 28 days in the hospital prior to admission. Review of an Order Summary Report for Resident 2 as of 8/12/24 revealed the resident had an order dated 7/3/24 to cleanse the resident's pressure ulcer to the coccyx with a wound cleanser, and then to apply Triad paste (topical zinc-oxide based paste for wounds with light to moderate levels of drainage which promotes a natural process that uses the body's own enzymes to breakdown dead tissue in wounds) every day and every evening. (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: 285092	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/14/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of wound care on 8/13/24 at 9:05 AM, Licensed Practical Nurse (LPN)-G washed hands and placed on a clean pair of gloves. No dressing was observed to the resident's pressure ulcer to the coccyx. The pressure ulcer measured approximately 1.5 centimeters (cm) by 2.5 cm with white tissue to the wound bed and pink healing tissue to the outer edges of the wound. LPN-G sprayed a cleanser to the wound bed and patted the area dry. LPN-G applied skin prep (skin protectant that prepares damaged skin for adhesive dressing or protects skin from incontinence or wound drainage) to the edges of the wound and allowed to dry. LPN-G then applied a small amount of Medi-honey (gel/ointment with antibacterial, anti-inflammatory, and debriding effects) directly to staff's glove and placed onto the wound. LPN-G removed gloves and washed hands in the resident's bathroom. During an interview on 8/13/24 at 9:25 AM, LPN-G confirmed completing the wrong dressing change to Resident 2's coccyx pressure ulcer.

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NAME OF PROVIDER OR SUPPLIER: Emerald Nursing & Rehab Columbus		STREET ADDRESS, CITY, STATE, ZIP CODE: 2855 40th Avenue Columbus, NE 68601	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.18 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 direct cares for Residents 3 and 4 who were on Enhanced Barrier Precautions; and 2) complete hand hygiene (hand washing using soap and water or an alcohol based hand rub) and gloving techniques during the provision of a treatment to prevent potential cross contamination during the provision of wound care for Resident 3. The sample size was 5 and the facility census was 79. Findings are: A. Review of the facility policy PPE-Enhanced [NAME] Precautions (EBP) with a revision date of 1/24 revealed EBP are an infection control intervention designed to reduce transmission of resistive organisms that employs targeted gown and glove use during high contact resident care activities. EBP may be indicated for residents with wounds or indwelling medical devices. EBP requires the use of gown and gloves only for high-contact resident care activities (dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care and/or use and wound care). B. Review of the facility policy Handwashing/Hand Hygiene with a revision date of 1/24 revealed the facility considered hand hygiene the primary means to prevent the spread of infections. Handwashing and hand hygiene was to be completed for the following: -when hands were visibly soiled, -before and after coming on duty, -before preparing or handling medications, -before putting on and when taking off gloves, and -before moving from a contaminated body site to a clean body site during resident cares. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. During an observation of resident cares on 8/13/24 at 10:35 AM, Resident 3 was positioned in a wheelchair in the resident's room. A sign on the doorframe of the resident's room indicated the resident was on EBP. Nurse Aide (NA)-D and Medication Aide (MA)-E entered the room to transfer the resident into bed for a dressing change. Both staff completed hand hygiene and placed on gloves but failed to put on gowns. MA-E removed the soiled linens and then proceeded to place clean linens on Resident 3's bed. The full lift (mechanical device that allows residents to be transferred between a bed and a chair using hydraulic power and requires no weight bearing assistance from the resident) was positioned in front of the resident and still without putting on the required PPE, NA-D and MA-E transferred the resident out of the wheelchair and onto the resident's bed. Registered Nurse (RN)-F entered the resident's room, washed hands in the resident's handwashing sink, then placed on a gown and gloves. RN-F removed the dressing from the resident's coccyx area and discarded. Without changing gloves, RN-F sprayed the resident's pressure ulcer with a wound wash, patted dry with gauze and dispensed a moderate amount of barrier cream from the container directly to soiled gloves. RN-F then applied a thick layer of the barrier cream directly to the wound bed. Still without removing soiled gloves, RN-F opened a clean dressing and placed over the coccyx wound. RN-F removed soiled gloves and without washing hands or completing hand hygiene, proceeded to assist MA-E with placing a clean disposable urinary incontinent brief on the resident and adjusting the resident's clothing. D. Observations of resident cares on 8/14/24 at 8:45 AM revealed Resident 4 was lying supine in bed. Resident 4 had a sign on the doorframe of the resident's room which indicated the resident was on EBP. NA-M entered the resident's room washed hands and placed on a clean pair of gloves. NA-M assisted the resident with dressing, transfer into the bathroom, toileting/hygiene cares and changing the resident's urine soiled bed linens without the use of a disposable gown. E. During an interview on 8/14/24 at 2:00 PM, the Director of Nursing (DON) confirmed the following: -Resident 3 was on EBP as the resident had a pressure ulcer to the coccyx. -NA-D and MA-E should have worn a gown as well as gloves when changing the Resident 3's bed and transferring the resident from the wheelchair to the bed. -RN-F should have removed soiled gloves after removing the dressing and applying barrier cream to Resident 3's coccyx, washed hands and placed on clean gloves before putting the clean dressing on the resident's pressure ulcer. -Resident 4 was on EBP due to a pressure ulcer to the resident's right lower leg. -NA-M should have worn gloves and a gown when assisting Resident 4 with direct cares.