

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 07/18/2024
NAME OF PROVIDER OR SUPPLIER Emerald Nursing & Rehab Columbus		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638</p> <p>Licensure Reference Number 175 NAC 12-006.19 (A)</p> <p>Based on observation, and interview, the facility failed to maintain the cleanliness and condition of walls, floors, and a baseboard in 5 (rooms: Northwest 7 and 10, Northeast 4, East 7 and [NAME] 5) of 68 occupied resident rooms and the Northwest corridor between rooms [ROOM NUMBERS]. The facility census was 73.</p> <p>Findings are:</p> <p>Observations on 7/18/24 from 11:30 AM to 12:06 PM, during the environment tour, revealed the following concerns with the facility environment:</p> <p>Northwest corridor</p> <ul style="list-style-type: none"> -missing base board in the hallway between rooms [ROOM NUMBERS], -room [ROOM NUMBER] with scrapes and gouges and a hole in the drywall approximately 4 by 10 inches underneath of the air conditioning unit and the adjacent wall with gouged/scraped areas, -room [ROOM NUMBER] in the resident's bathroom above the stool was a hole/gouged area in the drywall which measured approximately 4 by 6 inches. <p>Northeast Corridor</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] had an area underneath of the window with a patch panel that had been screwed into the wall which measured approximately 20 by 32 inches. <p>East Corridor</p> <ul style="list-style-type: none"> -room [ROOM NUMBER] next to the resident's bed was a hole/gouged area in the drywall which measured approximately 4 x 6 inches. <p>West Corridor</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-room [ROOM NUMBER] with a transition stop strip between flooring in the resident's room and the corridor. Right side of the strip was loose and no longer affixed to the floor with exposed flooring having a black discoloration with dirt/debris.</p> <p>An interview with the Administrator on 7/18/24 at 11:42 AM confirmed the areas identified on the environment tour needed to be cleaned and/or repaired.</p> <p>During an interview on 7/18/24 at 12:30 PM, the Maintenance Director (MD) indicated the patch panel had been affixed to the wall in room [ROOM NUMBER] on the Northeast corridor as the wall had caved in . The MD reported a Maintenance Request Log was kept on a clip board at the Nurse's Station, but the areas of concern had not been identified prior to the environmental tour of the facility.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>29638</p> <p>LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(l)(i)</p> <p>Based on observations, record review and interviews; the facility failed to implement fall interventions and to revise current interventions and/or develop new intervention to prevent ongoing falls for Resident 69. The sample size was 5 and the census was 73.</p> <p>Findings are:</p> <p>A. Review of the facility policy Falls Management with a revision date of 1/24 revealed the residents were to be assessed to determine fall risk and then the interdisciplinary team (IDT) were to identify and implement appropriate interventions to reduce the risk of falls or injuries. The following procedures were indicated:</p> <ul style="list-style-type: none"> -assess the resident's fall risk at admission, quarterly, with a change in condition or a fall. -implement goals and interventions based on the individual's needs. -communicate interventions to the team. -educate the staff, resident, and responsible party regarding interventions. -provide training to staff as needed and document. <p>B. Review of Resident 69's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 4/26/24 revealed diagnoses of adult failure to thrive, previous heart attack with rapid, irregular heartrate and pain. The following was assessed regarding the resident:</p> <ul style="list-style-type: none"> -cognition was moderately impaired, -displayed behaviors which included verbal and physical behaviors directed at others, other behavioral symptoms (hitting or scratching self, pacing, rummaging, public sexual acts, throwing or smearing food or bodily wastes or verbal/vocal sounds) not directed at others and rejection of cares, -dependent with dressing, bed mobility and transfers, and -one fall without injury since the previous assessment. <p>Review of Fall Scene Investigation Reports for Resident 69 revealed the following:</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-4/22/24 at 12:30 AM the resident was found sitting on the foot pedals of the wheelchair in the resident's room. Interventions in place included the resident's call light was in reach and the resident wore non-skid footwear. The resident indicated wanting to go to bed and had tried to transfer self. A new intervention was identified to ask the resident earlier in the shift if ready to go to bed and to provide assist when ready.</p> <p>-5/9/24 at 9:51 AM the resident was found on the floor next to the resident's bed. The call light was in reach and the resident wore gripper socks. Interventions to place the resident's bed in the lowest position and for a fall mat to be placed next to the bed were identified.</p> <p>-5/21/24 at 8:20 AM the resident was found on the floor next to the bed. The investigation indicated an alarm was sounding at the time of the fall, the resident's call light was in reach and the resident was wearing non-skid footwear. Further review of the investigation revealed no evidence the fall mat was on the floor next to the resident's bed or if the bed had been placed in the lowest position. A new intervention was identified for positioning bars to be placed on the bed.</p> <p>-5/31/24 at 5:24 AM the resident was found on the floor in the resident's room between the bed and the bathroom. Further review of the investigation revealed no documentation to indicate if the resident's bed had been placed in the lowered position, if the repositioning bars were placed on the bed, and if an alarm and/or the fall mat were utilized. In addition, there was no documentation to indicate a new intervention was developed to prevent further falls.</p> <p>-6/18/24 at 5:42 AM the resident was lying on the floor next to the bed in the resident's room. The report indicated the bed had not been placed in the lowered position and there was no evidence the fall mat was in place at the time of the fall. There were no revisions of current interventions or evidence additional interventions were developed.</p> <p>-6/23/24 at 4:35 PM the resident was found on the floor between the nightstand and the resident's bed. The report identified a fall alarm was to be placed on the resident's bed (investigation dated 5/21/24 at 8:20 AM indicated an alarm was in place and sounding) and a Medication review was to be conducted.</p> <p>Observations of Resident 69 in the resident's room revealed the following:</p> <p>-7/15/24 at 10:11 AM, 10:25 AM and 11:45 PM the resident was seated in the wheelchair. A sensor pad fall alarm (electronic pressure sensitive pad designed for use in chairs or beds which will alarm if a resident tries to get up without assistance) was positioned on the resident's bed and a second alarm had been placed on the bedside dresser. No alarm had been placed on the resident's wheelchair. The resident's call light cord was pooled on the floor behind the resident and not within reach for the resident to utilize.</p> <p>-7/15/24 at 2:05 PM the resident was lying in bed. The bed had been placed in the lowered position, a sensor pad fall alarm was in place as well as repositioning bars to the bed and the call light was in reach. However, no fall mat was in place on the floor next to the resident's bed.</p> <p>-7/16/24 at 11:00 AM the resident was seated in a wheelchair to the left side of the resident's bed with the sensor pad fall alarm in place. The call light was secured to the positioning bar which was located on the right side of the bed and was not in easy reach of the resident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with Nurse Aide (NA)-S on 7/16/24 at 11:40 AM revealed the resident was to have the call light within reach and was to have the sensor pad fall alarm always on to prevent further falls. NA-S was uncertain as to use of the fall mat and confirmed there was no fall mat in the resident's room.</p> <p>Interview with the Director of Nursing (DON) on 7/17/24 at 2:13 PM verified the following:</p> <ul style="list-style-type: none"> -new interventions were developed for use of a fall mat next to the resident's bed and for the resident's bed to be placed in the lowered position after the resident's fall on 5/9/24 at 9:51 AM. -no new interventions were developed after the resident's fall on 5/31/24 at 5:24 AM. At some point, the DON had removed the fall mat from the resident's room as the DON felt this was too great of a trip hazard for the resident. However, there was no documentation as to when the fall mat was removed. -the resident's bed had not been placed in the lowered position prior to the resident's fall on 6/18/24 at 5:42 AM. There was no documentation to determine if the staff had received education regarding implementation of the intervention. No further fall interventions were developed and/or implemented.

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>29638</p> <p>Licensure Reference Number 175 NAC 12-006.12(A)(vi)</p> <p>Based on record review and interview, the facility failed to ensure residents were free from unnecessary medications related to long term use of an antibiotic medication for Resident 22. The antibiotic did not specify a duration and had no supporting documentation for clinical use based on laboratory results. The sample size was 2 and the facility census was 73.</p> <p>Findings are:</p> <p>A. Review of the facility Antibiotic Stewardship Policy dated 11/17 revealed the following:</p> <ul style="list-style-type: none"> -the purpose of the program was to reduce inappropriate use of antibiotics, improve resident outcomes and lessen adverse events. -antibiotic stewardship was to be part of the Infection Control Program. -the facility was to track antibiotic use daily. -all nurses were to be educated regarding proper assessment for infection prior to calling a physician. -the facility was to ensure the pharmacy reviewed all antibiotic usage for appropriateness. -the facility would monitor for any adverse reactions/outcomes related to use of antibiotics. <p>B. Review of Resident 22's medical record revealed the following:</p> <ul style="list-style-type: none"> -4/5/23 at 10:35 AM the resident was seen by the urologist due to use of an indwelling Foley catheter. Urine in the drainage bag appeared cloudy and a new order was received to start Cefadroxil (antibiotic used to stop the growth of bacteria) 500 milligrams (mg) daily indefinitely. -4/25/23 at 11:28 PM the indwelling Foley catheter was removed per order of the urologist. -4/26/23 at 8:10 AM the resident was out of the facility at the urologist. Further review revealed no evidence the urologist addressed the continued use of the Cefadroxil 500 mg daily. -5/22/23 the consultant pharmacist completed a monthly medication review and requested the resident's physician address the continued daily use of the Cefadroxil 500 mg daily. -6/5/23 the resident's primary physician indicated use of the Cefadroxil should be addressed at the resident's urology appointment on 7/12/23. -7/12/23 the resident was seen by the urologist. Review of the resident's medical record revealed no evidence the continued use of the Cefadroxil 500 mg daily was assessed. <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-3/7/24 at 12:18 PM a Nursing Progress Note indicated the resident had a urinalysis collected due to the resident's complaints of pain and burning with urination.</p> <p>-4/19/24 a facsimile (fax) was sent to the resident's primary physician regarding the continued use of the Cefadroxil since 2023.</p> <p>-4/22/24 the resident's primary physician again refused to address use of the Cefadroxil indicating the medication had been ordered by the urologist.</p> <p>-5/22/24 at 11:15 AM the resident was seen by the urologist. The urologist was asked if continued use of the Cefadroxil was warranted and if so, what diagnosis should be used. Review of the Physician Visit form revealed the urologist did not address the diagnosis or the continued use of the Cefadroxil but indicated a urine culture was pending.</p> <p>-6/4/24 a new order was received for Amoxicillin (antibiotic used to treat bacterial infections) 875 mg take 1 tablet twice a day for 14 days.</p> <p>Review of the resident's Medication Administration Record (MAR) dated 7/24 revealed the resident continued to receive the Cefadroxil 500 mg daily indefinitely which was ordered 4/6/23 for history of urinary tract infections.</p> <p>An interview with the Infection Preventionist dated 7/18/24 at 10:01 AM confirmed the following:</p> <p>-the resident was started on the Cefadroxil 500 mg daily by the urologist 4/5/24. At the time the resident was seen by the urologist, the resident had an indwelling Foley catheter and at the appointment, the resident's urine was cloudy. However, there was no urinalysis completed at the office prior to the initiation of the antibiotic.</p> <p>-per the urologist the resident's indwelling catheter was discontinued 4/25/23.</p> <p>-5/22/23 the consultant pharmacist reviewed the resident's medications and made a recommendation to address the long-term use of the antibiotic based on the potential harm associated with long-term use.</p> <p>-6/5/23 the resident's primary physician indicated the resident should continue the antibiotic and use of the medication should be addressed by the urologist.</p> <p>-seen by the urologist 7/12/23 and use of the antibiotic was not addressed by the urologist.</p> <p>-the resident had a urinalysis completed 3/7/24 due to complaints of burning when the resident voided but there was no evidence of an infection.</p> <p>-4/19/24 the consultant pharmacist again addressed use of the antibiotic.</p> <p>-4/22/24 the primary physician refused to address use of the antibiotic and indicated use should be reviewed by the urologist.</p> <p>(continued on next page)</p>

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-5/22/24 seen by the urologist and a urinalysis was obtained. Though the facility asked about the continued use of the Cefadroxil, the urologist again failed to address and indicated the office was waiting for the culture report.</p> <p>-6/3/24 the facility had not heard any information regarding the impending culture of the urinalysis obtained 5/22/24 and attempted to contact the urologist.</p> <p>-6/4/24 a new order was received for Amoxicillin 875 mg take 1 tablet every 12 hours for 14 days.</p> <p>-the resident continued to receive the Cefadroxil without a stop date.</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>29638</p> <p>LICENSURE REFERENCE NUMBER 175 NAC 12-006.10D</p> <p>Based on observation, record review and interview; the facility staff failed to ensure a medication error rate of less than 5 percent (%). Observations of 27 medications administered revealed 6 errors resulting in an error rate of 22.22%. The medication errors were related to 3 (Residents 5, 19 and 68) of 6 residents. The facility staff identified a census of 73.</p> <p>Findings are:</p> <p>A. Review of the facility policy Medication Errors with a revision date of 1/24 revealed the facility was to ensure residents were free of medication error rates of 5% or greater. A medication error was defined as the observed or identified preparation or administration of medications which were not in accordance with the prescriber's order or the manufacturers specifications regarding the preparation and administration of the medication.</p> <p>B. Review of Resident 5's Medication Administration Record (MAR) dated 7/2024 revealed the resident had an order dated 4/13/23 for Metformin (medication used to treat diabetes) 1000 milligrams (mg) to take 1 tablet twice a day with food.</p> <p>Observations on 7/17/24 revealed the following:</p> <p>-7:45 AM Licensed Practical Nurse (LPN)-G administered the Metformin to Resident 5 in the resident's room. The resident was not offered food when the medication was administered.</p> <p>-8:30 AM (45 minutes later) the resident was in the dining room and was served the breakfast meal.</p> <p>C. Review of Resident 19's MAR dated 7/2024 revealed the following orders:</p> <p>-Glimepiride (medication used to treat diabetes) 4 mg 1 tablet daily to take with food ordered 10/27/22,</p> <p>-Metformin 100 mg take 1 tablet daily with food ordered 10/27/22,</p> <p>-Potassium Chloride 20 milliequivalents take 1 tablet with a full glass of water and take with food ordered 11/28/22, and</p> <p>-Aspirin 81 mg take 1 tablet daily with food ordered 11/28/22.</p> <p>Observations on 7/17/24 revealed the following:</p> <p>-7:23 AM LPN-P administered the Glimepiride, Metformin, Potassium Chloride, and the Aspirin to Resident 19 in their room. The medications were not administered with food and the resident did not receive a full glass of water with the medications.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-8:43 AM (1 hour and 10 minutes later) the resident was in the dining room and was served the breakfast meal.</p> <p>D. Review of Resident 68's MAR for 7/2024 revealed the resident had an order dated 5/23/24 for Meloxicam (anti-inflammatory medication used to treat arthritis) 15 mg 1 tablet daily. The order further indicated the medication was to be taken with food.</p> <p>Observation on 7/17/24 revealed the following:</p> <p>-7:15 AM LPN-P administered the Meloxicam to Resident 68 in the resident's room. The resident was not offered food at the time the medication was administered.</p> <p>-8:35 AM (1 hour and 15 minutes later) the resident was served their breakfast meal in the dining room.</p> <p>E. During an interview on 7/17/24 at 1:58 PM, the Director of Nursing (DON) verified Residents 5, 19, and 68 should have received their medications with food and staff should have administered during the breakfast meal.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>42360</p> <p>Licensure Reference Number 175 12-006.04(H)</p> <p>Based on observation, interview, and record review; the facility failed to ensure they employed a Certified Dietary Manager (CDM) and staffing sufficient to clean the kitchen environment, food preparation equipment and storage equipment in a manner to prevent potential food borne illness. This had the potential to affect all residents who ate food prepared by the facility. The facility census was 73.</p> <p>Findings are:</p> <p>Review of the facility Job Description for Manager of Dining Services dated 10/1/16 revealed the following:</p> <ul style="list-style-type: none"> -The Dietary Manager managed the operation of the dietary department to include staff, food ordering and preparation, food delivery and clean-up in accordance with facility policies, physician's orders, patient care plans and appropriate regulations. -Ensured food was nutritional, appetizing, prepared per menu and recipes and served in a timely manner. -Ensured equipment and work areas were clean, safe and orderly, ensured strict adherence to procedures regarding cleaners and or hazardous materials or objects, ensured universal precautions and infection control, isolation, fire, safety and sanitation practices and procedures were followed and promptly addressed any hazardous conditions or equipment. <p>During the initial brief tour of the primary kitchen on 7/15/24 at 7:15 AM the following was identified:</p> <p>The kitchen floor was covered in a sticky substance causing shoes to stick to the floor when walking.</p> <ul style="list-style-type: none"> -the grout in the floor tiles was covered in food debris, especially on the floor just in front of the steam table in which food is served from. -the floor beneath the refrigerators, working and food prep surfaces, below the ovens, dishwasher, sinks, and all equipment/table legs and the floor base where they sat, were coated with a thick black substance and food debris. The floor beneath the ovens had a thick layer of food debris present. -The surface of the fire suppression system just above the oven was coated in thick brown sticky substance and the paint was peeling away from the metal surface. -The oven doors were coated with burnt on food and the insides of the ovens had a thick layer of black burnt food. <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The inside surface, outside door and below the food steamer were coated in a white substance and one steamer was dripping water into a pan beneath the steamer; the water was full to the top of the pan and cloudy colored.</p> <p>-The walls above and adjacent to the oven was covered in a brown colored sticky substance that had been dripping down the walls.</p> <p>-The wall behind a second fire suppression system located above the food steamer also was coated in the brown dripping sticky substance as was one side of the fire suppression system. Pans used for baking food were located directly below the wall and fire suppression system where the sticky substance was seen.</p> <p>-All the facility cooking pots located on a shelf were coated in a thick layer of black carbon build up on the outside surfaces of the pots extending 1/2 way up the pots.</p> <p>-The air return covers throughout the kitchen had chipping paint and rust spots present.</p> <p>-Just below a pan catching the drippings from the food steamer, was a bin of flour and a bin of sugar. The flour bin was noted to have a brown substance dripping inside of the bin from the pan above it, onto the flour turning the flour a brown color.</p> <p>-The sink in the dishwasher room was dripping at a constant slow trickle, the piping beneath the sink was dripping, and a pan was beneath the sink drain catching the dripping water. The water in the pan was milky and cloudy in appearance.</p> <p>-the doors of the reach-in refrigerators were covered in handprints/smears and the lower portions of the refrigerator surfaces were coated with food debris.</p> <p>-The bottom shelf of the reach-in freezer had frozen orange colored liquid present and a box of vegetables (Okra) stuck in the frozen substance.</p> <p>-The dry food storage area had 4 boxes of unpacked food sitting directly on the floor.</p> <p>-The walk-in freezer had 2 boxes of food stored directly on the floor.</p> <p>-Two food service carts used for transporting food within the kitchen were covered in food crumbs and stuck on food debris.</p> <p>-A food cart with a toaster on it was also heavily covered with food debris and crumbs.</p> <p>-Any/all equipment or items with wheels had heavily soiled wheels.</p> <p>During an initial tour of the secondary kitchen on 7/15/24 at 7:55 AM the following was revealed:</p> <p>-The floor in the secondary kitchen was also sticky and the grout was heavily soiled.</p> <p>-The floor beneath the refrigerators, below the steam table, anywhere legs of equipment were on the floor, and the surrounding areas were heavily soiled.</p> <p>(continued on next page)</p>		

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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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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The lid to the ice machine was hanging down on one side and the surfaces of the ice machine was soiled with a white substance and evidence of dripping water.</p> <p>-The ice machine also had chipping paint on the side of it.</p> <p>-The dishwashing room floor and surfaces were also covered in lime build up and the sink drains were heavily coated in a brown substance.</p> <p>During an interview on 7/15/24 at 7:40 AM with the Dietary Manager (DM) revealed the DM had no current certification but was enrolled in classes. The DM confirmed the facility had no evidence they were completing routine cleaning of the environment and the facility equipment. In addition, the DM confirmed the facility sink in the dishwashing room had been leaking for a least 6 months and a request had been submitted to the maintenance department for repair. The DM confirmed that often the deep cleaning was not getting completed due to staffing concerns.</p> <p>During an interview on 7/15/24 at 8:00 AM with Dietary Staff (DS)-A confirmed cleaning often did not happen, as staff did not have time to clean equipment during the course of a work shift.</p> <p>During a tour of the kitchens on 7/15/24 at 10:30 AM the facility Administrator confirmed the condition of the kitchen walls, floors, food preparation/storage equipment, leaking faucets and drains and fluid dripping into the flour bin from the food steamer was not acceptable. In addition, the Administrator confirmed the DM had not completed the required training and was cooking frequently, not allowing for time to ensure the environment and equipment was being adequately maintained.</p> <p>During an interview on 7/18/24 at 2:45 PM the facility Administrator confirmed the Dietary Manager was not certified, was cooking most of the time, and had the facility had no evidence the kitchen environment and equipment was being cleaned on a routine basis.</p>

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>29638</p> <p>LICENSURE REFERENCE NUMBER 175 NAC 12-006.11D</p> <p>Based on observation, record review and interview; the facility failed to ensure room trays were palatable and served at the proper temperature. This affected 2 (Residents 34 and 66) of 4 residents served a breakfast room tray. The facility staff identified a census of 73.</p> <p>Findings are:</p> <p>A. Review of the facility Beginning Food Cooking Temperatures log (form used to document food temperatures before each meal service) revealed the serving temperatures of all hot food was to be a minimum of 140 degrees Fahrenheit (F) before serving to the residents. Further review of the log revealed on 7/15/24 at the breakfast meal the scrambled eggs had a temperature of 182 degrees.</p> <p>B. Observations on 7/15/24 revealed the following:</p> <p>-8:10 AM a serving cart was positioned next to the Nurse's Station by the [NAME] corridor. The cart contained 4 breakfast room trays with a thermal cover over each of the plates.</p> <p>-8:50 AM (40 minutes later) Nurse Aide (NA)-S approached the cart, removed one of the trays and deliver the room tray to Resident 34. NA-S removed the thermal covering and revealed a serving of scrambled eggs.</p> <p>-9:00 AM Dietary Aide (DA)-dd obtained a temperature of 78 degrees F for the scrambled eggs.</p> <p>-9:02 AM Resident 66 had also received a breakfast room tray which contained scrambled eggs which had a temperature of 74 degrees F.</p> <p>An interview with DA-dd on 7/15/24 at 9:10 AM confirmed the scrambled eggs should have been a minimum of 140 degrees F before being served to the residents. DA-dd reported the breakfast room trays had been prepared somewhere between 7:30 AM to 7:45 AM that morning and the kitchen staff then placed them by the Nurse's Station for the Nursing staff to distribute.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42360</p> <p>Licensure Reference Number 175 NAC 12-006.11(E)</p> <p>Based on observation, interview, and record review; the facility failed to ensure the kitchen environment, food storage, and preparation equipment were maintained in a manner to prevent the potential for food borne illness. This had the potential to affect all facility residents who ate food prepared by the facility kitchen. The facility census was 73.</p> <p>Findings are:</p> <p>Review of the 7/21/2016 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:</p> <p>-4-602.13 Nonfood contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residue.</p> <p>-4-601.11(B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations.</p> <p>-4-601.11(C) Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>-4-903.11(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.</p> <p>-6-2-01.11 Cleanability, Floors, Walls, and Ceilings. Except as specified under 6-201.14 and except for anti-slip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable.</p> <p>During the initial brief tour of the primary kitchen on 7/15/24 at 7:15 AM the following was identified:</p> <p>The kitchen floor was covered in a sticky substance causing shoes to stick to the floor when walking.</p> <p>-the grout in the floor tiles was covered in food debris, especially on the floor just in front of the steam table in which food is served from.</p> <p>-the floor beneath the refrigerators, working and food prep surfaces, below the ovens, dishwasher, sinks, and all equipment/table legs and the floor base where they sat, were coated with a thick black substance and food debris. The floor beneath the ovens had a thick layer of food debris present.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The surface of the fire suppression system just above the oven was coated in thick brown sticky substance and the paint was peeling away from the metal surface.</p> <p>-The oven doors were coated with burnt on food and the insides of the ovens had a thick layer of black burnt food.</p> <p>-The inside surface, outside door and below the food steamer were coated in a white substance and one steamer was dripping water into a pan beneath the steamer; the water was full to the top of the pan and cloudy colored.</p> <p>-The walls above and adjacent to the oven was covered in a brown colored sticky substance that had been dripping down the walls.</p> <p>-The wall behind a second fire suppression system located above the food steamer also was coated in the brown dripping sticky substance as was one side of the fire suppression system. Pans used for baking food were located directly below the wall and fire suppression system where the sticky substance was seen.</p> <p>-All the facility cooking pots located on a shelf were coated in a thick layer of black carbon build up on the outside surfaces of the pots extending 1/2 way up the pots.</p> <p>-The air return covers throughout the kitchen had chipping paint and rust spots present.</p> <p>-Just below a pan catching the drippings from the food steamer, was a bin of flour and a bin of sugar. The flour bin was noted to have a brown substance dripping inside of the bin from the pan above it, onto the flour turning the flour a brown color.</p> <p>-The sink in the dishwasher room was dripping at a constant slow trickle, the piping beneath the sink was dripping, and a pan was beneath the sink drain catching the dripping water. The water in the pan was milky and cloudy in appearance.</p> <p>-the doors of the reach-in refrigerators were covered in handprints/smears and the lower portions of the refrigerator surfaces were coated with food debris.</p> <p>-The bottom shelf of the reach-in freezer had frozen orange colored liquid present and a box of vegetables (Okra) stuck in the frozen substance.</p> <p>-The dry food storage area had 4 boxes of unpacked food sitting directly on the floor.</p> <p>-The walk-in freezer had 2 boxes of food stored directly on the floor.</p> <p>-Two food service carts used for transporting food within the kitchen were covered in food crumbs and stuck on food debris.</p> <p>-A food cart with a toaster on it was also heavily covered with food debris and crumbs.</p> <p>-Any/all equipment or items with wheels had heavily soiled wheels.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an initial tour of the secondary kitchen on 7/15/24 at 7:55 AM the following was revealed:</p> <ul style="list-style-type: none"> -The floor in the secondary kitchen was also sticky and the grout was heavily soiled. -The floor beneath the refrigerators, below the steam table, anywhere legs of equipment were on the floor, and the surrounding areas were heavily soiled. -The lid to the ice machine was hanging down on one side and the surfaces of the ice machine was soiled with a white substance and evidence of dripping water. -The ice machine also had chipping paint on the side of it. -The dishwashing room floor and surfaces were also covered in lime build up and the sink drains were heavily coated in a brown substance. <p>During an interview on 7/15/24 at 7:40 AM with the Dietary Manager (DM) revealed the DM had no current certification but was enrolled in classes. The DM confirmed the facility had no evidence they were completing routine cleaning of the environment and the facility equipment. In addition, the DM confirmed the facility sink in the dishwashing room had been leaking for a least 6 months and a request had been submitted to the maintenance department for repair. The DM confirmed that often the deep cleaning was not getting completed due to staffing concerns.</p> <p>During an interview on 7/15/24 at 8:00 AM with Dietary Staff (DS)-A confirmed cleaning often did not happen, as staff did not have time to clean equipment during the course of a work shift.</p> <p>During a tour of the kitchens on 7/15/24 at 10:30 AM the facility Administrator confirmed the condition of the kitchen walls, floors, food preparation/storage equipment, leaking faucets and drains and fluid dripping into the flour bin from the food steamer was not acceptable. In addition, the Administrator confirmed the DM had not completed the required training and was cooking frequently, not allowing for time to ensure the environment and equipment was being adequately maintained.</p> <p>During an interview on 7/18/24 at 2:45 PM the facility Administrator confirmed the Dietary Manager was not certified, was cooking most of the time, and had the facility had no evidence the kitchen environment and equipment was being cleaned on a routine basis.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45739</p> <p>Licensure Reference Number NAC 175 12-006.18</p> <p>Based on record review and interview; the facility failed to implement their legionella water management policy to prevent the potential for water-borne illness. This had the potential to affect all residents. The facility census was 73.</p> <p>Findings are:</p> <p>Review of the facility policy: Legionella (bacteria that causes pneumonia like illness) Water Management Program, last revised 1/2024 revealed the following:</p> <ul style="list-style-type: none"> -the water management team would consist of at least the infection preventionist, the administrator, the medical director, the director of maintenance, and the director of environmental services, -the purpose was to identify areas in the water system where Legionella bacteria could grow and spread, and to reduce the risk of Legionnaire's disease (severe form of pneumonia), and -the water management program would include the following: <ul style="list-style-type: none"> a. an interdisciplinary water management team, b. a detailed description and diagram of the water system, c. identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria and the identification of situations that could lead to legionella growth such as stagnation, d. specific measures used to control the introduction and/or spread of Legionella, e. the parameters that were acceptable and were monitored, f. a diagram of where control measures were applied, g. a system to monitor control limits and the effectiveness of control measures, h. a plan for when control limits were not met and/or control measures were not effective, and i. documentation of the program, and j. the water management program would be reviewed at least once a year. <p>Interview on 7/18/24 at 10:50 AM with the Maintenance Director revealed maintenance was not performing any measures to prevent the growth of legionella.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview on 7/18/24 at 11:45 AM with the Infection Preventionist revealed that the maintenance department was in charge of performing the measures for the preventing the growth of legionella.</p> <p>Interview on 7/18/24 at 2:05 PM with the Administrator confirmed the facility had no documentation that they were taking measures to prevent the growth of legionella and had not implemented their water management policy.</p>