STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.04C3a(6) Based on record review and interview; the facility failed to notify Resident 2's Primary Care Physician (PCP) of the resident's change in fluid buildup, mental status, and behaviors. The sample size was 1 and the facility census was 62. Findings are: A. Review of the facility policy Provider Notice of Adverse Event and/or Change in Condition with a review date of 6/5/23 revealed the facility staff were to assure timely and appropriate notification to the PCP regarding changes in condition and adverse events. A change in condition was defined as any significant alteration in a resident's physical, mental, or emotional state that may require medical intervention or adjustment of the resident's care plan. B. Review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 3/28/24 revealed the resident was admitted [DATE] with diagnoses of paranoid schizophrenia, diabetes, cerebral palsy, depression, and anxiety. The assessment identified the resident was having behavior symptoms not directed at others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily waste and verbal/vocal symptoms like screaming or making disruptive sounds) and rejection of cares. The assessment further indicated the resident was receiving the following medications: an antipsychotic (a type of psychoactive medication which alters chemicals in the brain to effect changes in behavior, mood, and emotion), an antidepressant (medication used to treat depression), and an antianxiety (medication used to treat anxiety). Review of Resident 2's Nursing Progress Notes revealed the following: -5/17/24 at 2:04 PM the resident returned from the hospital. The resident was seated in a wheelchair, awake and alert. The resident was assisted to the resident's room and then immediately started to cry. -5/18/24 at 2:20 AM the resident had refused to be toileted and refused to go to bed. The resident was making strange noises and had placed personal belongings in a trash receptacle in the resident's room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/18/24 at 8:19 AM the resident reported hearing voices and of feeling afraid. At times staff were able to hear the resident screaming and yelling in the resident's room. -5/18/24 at 1:21 PM the resident was combative and resistive with cares, made repetitive statements, was continually removing shirt, shredding Kleenex onto the floor and chewing up food only to spit it back out onto the resident or the floor. -5/18/24 at 10:26 PM the resident was seated in a chair in the resident's room and was making loud, odd noises. The resident was rocking back and forth and was incontinent of bladder. -5/18/24 at 11:28 PM the resident was lying in bed and was growling loudly. The resident pulled the electric cords plugged into the wall socket and was banging on the wall. Staff responded to the resident's call light and found the resident with the call light cord wrapped multiple times around the resident's head. -5/19/24 at 6:00 AM the resident was found with chunks of hair pulled out of the resident's head and lying on the floor. -5/19/24 at 6:18 AM the resident had been awake throughout the night. The resident was now in room and was speaking the same word over and over and was rocking continuously. -5/19/24 at 8:27 AM speech was nonsensical and pressured. The resident would repeatedly bend at the waist and then sit back up in the chair while chanting. -5/19/24 at 9:30 AM the resident was seated in a chair in the resident's room, rolling head around in a non-stop circle and repeating the word no. -5/19/24 at 5:25 PM staff reported the resident had been moving nonstop since the day shift had started. The resident appeared uncomfortable with mental health issues. The resident was no longer able to control movements with hyperverbal and nonsensical speech patterns. -5/20/24 at 3:24 PM the resident had 3+ pitting edema (occurs when there is an excess fluid buildup in the body causing swelling. When pressure is applied to the swollen area a pit or indentation will remain. 3+ pitting edema is when pressure leaves an indentation of 5-6 millimeters (mm) that takes up to 60 seconds to rebound) to lower legs. -5/20/24 at 10:21 PM the resident had been awake and seated in a chair throughout the day with 4+ (pressure leaves an indentation of 8 mm or deeper which takes 2-3 minutes to rebound) pitting edema to legs. Legs were slightly warm to the touch and reddened. 5/21/24 at 8:14 AM the facility notified the resident's PCP regarding the resident's bilateral lower extremity edema. Review of the resident's electronic medical record from 5/18/24 to 5/20/24 revealed no evidence Resident 2's PCP was notified of the resident's escalating behaviors, lack of sleep, wrapping of the call light cord around the resident's head and the resident pulling out own hair. In addition, the facility did not notify the PCP of the resident's increased fluid retention and warmth/redness to lower extremities until 5/21/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 6/11/24 at 12:05 PM with the Director of Nursing (DON) confirmed the resident's PCP was sent a facsimile on 5/21/24 to update the PCP regarding the resident's increased fluid retention, warmth, and redness of lower extremities. However, the facility failed to notify the PCP of the resident's ongoing behaviors from 5/18/24, which included the resident wrapping the call light cord around their head, pulling out their own hair, inability/refusal to sleep, and repetitive chanting and movements.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 09(G)(i) Based on record review and interview the facility failed to complete the required Discharge Summary for Resident 63. The sample size was 2 and the facility census was 62. Findings are: Review of the facility policy Transfer and Discharge with a revision date of 5/21/24 revealed the following: -The facility permitted each resident to remain in the facility and not initiate transfer and or discharge except in limited circumstances. -A Resident initiated transfer or discharge meant the resident and or their representative provide notice of their intent to leave the facility. -The facility evaluated and determined the level of care needed for residents leaving the facility, and -completed a Discharge Summary including a recapitulation of the resident's stay, a final summary of the resident's status, reconciliation of the resident's medications and a post discharge plan of care. Review of Resident 63's Admission/Discharge Record dated 6/13/24 revealed the resident was initially admitted to the facility on [DATE] and discharged on [DATE]. Further Review of Resident 63's Medical Record revealed no evidence the facility had completed the required Discharge Summary. On 6/13/24 at 12:00 PM the Director of Nursing confirmed the facility had not completed the required Discharge Summary for Resident 63.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.09 Based on interview and record review, the facility failed to follow Resident 2's physician order regarding a fluid restriction, and Resident 3's physician orders related to daily weights and use of an as needed diuretic. The sample size was 5 and the facility census was 62. The findings are: A. Review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 3/28/24 revealed the resident was admitted [DATE] with diagnoses of coronary artery disease, paranoid schizophrenia, diabetes, cerebral palsy, depression, and anxiety. The assessment identified the resident was having behavior symptoms not directed at others (physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing, or smearing food or bodily waste and verbal/vocal symptoms like screaming or making disruptive sounds) and rejection of cares. The assessment further indicated the resident was receiving the following medications: an antipsychotic (a type of psychoactive medication which alters chemicals in the brain to effect changes in behavior, mood, and emotion), an antidepressant (medication used to treat depression), an antianxiety (medication used to treat anxiety) and a diuretic (medication used to increase passing of urine). Review of Resident 2's undated current Care Plan revealed the resident was at risk for weight fluctuations related to fluid retention. Interventions included a 1500 cubic centimeter (cc) fluid restriction. The resident was to receive 360 cc of fluids with each meal. The care plan further indicated the resident was not always compliant with fluid restriction as the resident was requesting an extra-large coffee at each meal. Review of the resident's Medication Administration Record (MAR) dated 6/2024 revealed an order dated 3/3/22 for the resident to receive 180 cc of fluid with the morning and the evening medication administrations and 60 cc of fluid at the 4:00 PM medication administration. Observations of Resident 2 on 6/10/24 at 9:32 AM revealed the resident was seated in the resident's room and was watching television. On a bedside dresser next to the resident was a water receptacle which contained 600 cc of water, two cans which each contained 120 cc of grape juice and a 20-ounce bottle of soda with approximately 10 ounces of the soda already consumed. On the floor next to the resident were an addition 18 bottles of soda which were each 20 ounces. Observations of Resident 2 on 6/11/24 revealed the following: -9:09 AM the resident was served a breakfast meal tray which consisted of a large cup of coffee which was 180 cc, 120 cc of milk, and 120 cc of grape juice. In addition, the resident's water receptacle had been filled with 600 cc of ice water. -10:11 AM the resident had consumed all the fluids on the breakfast room tray and the resident's water receptacle had approximately 100 cc consumed (a total of 520 cc of fluid). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12:30 PM the resident was served a room tray which consisted of a large coffee which was 180 cc, a 120-cc container of grape juice, a glass with 180 cc of water and the resident had a full 20-ounce soda on the tray. -2:29 PM the resident had consumed all the fluids served with the noon meal for an approximate total of 970 cc of fluid. An interview with Dietary Aide (DA)-A on 6/11/24 at 2:30 PM revealed the resident refused to come out to the dining room for any meals and consumed all meals in the resident's room. The dietary staff served the room trays and then picked up the trays when the resident was finished with eating. Dietary were then responsible for documenting the fluid intakes at meals. DA-A reported no knowledge the resident was on a fluid restriction. Interview with the Director of Nursing (DON) on 6/11/24 at 2:45 PM confirmed the resident was not compliant with the ordered fluid restriction and the facility allowed the resident to keep unlimited fluids in the resident's room to drink whenever the resident desired. B. Review of Resident 3's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, anemia, coronary artery disease, heart failure, non-Alzheimer's dementia, malnutrition, depression, and Parkinson's disease. The resident was assessed as having a weight of 218 pounds and the resident received the following medications: an antidepressant and a diuretic. Review of Nursing Progress Notes dated 5/2/24 revealed the following: -10:33 AM the resident was having increased weakness and shortness of breath. The resident had edema to bilateral ankles and during a transfer, the resident had increased shortness of breath and the resident's face turned purple. The resident's physician was notified, and the resident was transferred to the emergency room for evaluation. -3:04 PM the resident returned from the emergency room with new orders for daily weights, oxygen to keep saturations above 90 percent, and to administer breathing treatments as needed. Review of the Resident's MAR for 6/2024 revealed the resident had an order dated 4/29/24 for Lasix (diuretic medication used to treat fluid retention by increasing urine output) 40 mg daily as needed if the resident had a weight gain of 2 pounds or more in 1-day, increased leg swelling, increased shortness of breath and increased fluid retention. Review of the resident's Weights and Vitals Summary Form (a document used to record the resident's weights) revealed the following regarding the resident's weights: -5/2/24 weight was 220 pounds. -5/5/24 weight was 219 pounds, -5/6/24 weight was 215 pounds, -5/7/24 weight was 216 pounds, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-5/8/24 weight was 216 pounds, -5/9/24 weight was 217 pounds, -5/10/24 weight was 215 pounds, -5/11/24 weight was 219 pounds, -5/12/24 weight was 218 pounds, -5/13/24 weight was 217 pounds, -5/14/24 weight was 215 pounds, -5/15/24 weight was 218 pounds, -5/16/24 weight was 218 pounds, -5/17/24 weight was 218 pounds, -5/18/24 weight was 218 pounds, -5/19/24 weight was 218 pounds, -5/20/24 weight was 215 pounds, -5/27/24 weight was 213 pounds, and -6/10/24 weight was 212 pounds. Further review of the resident's weight documentation revealed no daily weights were obtained on 5/3, 5/4, 5/21 to 5/26, 5/28 to 5/31 and 6/1 to 6/9/24 (no weights were obtained 21 out of 40 days reviewed). In addition, the resident had a 4-pound weight gain on 5/11/24, and a 3-pound weight gain on 5/15/24. Review of the resident's May 2024 MAR revealed no as needed Lasix was administered to the resident despite the resident's weight gain of 2 or more pounds in one day. Interview with the DON on 6/13/24 at 12:09 PM revealed the resident did have an order for as needed Lasix 40 mg to be given with a 2-pound weight gain in 1 day and an order for daily weights. Staff failed to complete daily weights as ordered and to administer the as needed Lasix as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 12-006.09D2b Based on observation, record review and interview; the facility failed to provide assessment and monitoring of Resident 114's pressure ulcer (injuries to the skin and the tissue below the skin due to pressure) to ensure healing. The sample size was 3 and the facility census was 62. Findings are: A. Review of the facility policy Skin Care and Management with a revision date of 4/23/24 revealed the facility had established a systemic approach for prevention and management of pressure ulcers which included prompt assessment and treatment; intervention to reduce or remove underlying risk factors; and monitoring/modifying interventions as appropriate. A Licensed Nurse was to conduct a full body assessment on all residents at admission/readmission then weekly and after any newly identified pressure ulcer or skin alteration. Findings were to be documented in the medical record and the Primary Care Physician (PCP) notified. Assessments of any new pressure ulcers were to be completed weekly and staging (system used to determine the severity of a pressure ulcer) clearly identified. Weekly assessments were to be continued until the area was healed and were to include the following: -wound date onset, -wound type, -pressure ulcer stage if applicable, -wound measurements, -wound bed description, -type and amount of drainage, -wound edges and surrounding skin, -signs of infection, -pain, and -treatment/dressing used. B. Review of Resident 114's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 5/28/24 revealed the resident was admitted [DATE] with diagnoses of sepsis, anemia, pressure ulcer to the sacral region, depression, cancer of the bladder, malnutrition, and urinary tract infection. The facility staff assessed the following about the resident: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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	-cognition was moderately impaired, -substantial to maximal assistance was provided with dressing, and personal hygiene, -dependent with toileting hygiene, showering/bathing, bed mobility and transfers, -frequently involuntary of bowel, and -at risk for the development of pressure ulcer and currently had a stage 1 (intact skin with non-blanchable (discoloration of the skin that does not turn white when pressed) redness of a localized area) pressure ulcer. Review of Resident 114's current, undated Care Plan revealed the resident was at risk for altered skin integrity related to impaired mobility, bowel incontinence and history of pressure ulcers. The following interventions were identified: -Licensed Nurse was to complete a weekly assessment and to record and/or monitor for wound healing. Assessment was to include measurements of the width, length and depth of the ulcer, drainage and status of the wound bed and perimeter, -monitor nutritional status, and -pressure relieving devices to bed and chair. Review of a Nursing Progress Note dated 5/21/24 at 1:01 PM revealed the resident was admitted from an acute care hospital with a reddened buttock fold and a Mepilex dressing (dressing that absorbs drainage and maintains a moist wound environment) covered the coccyx (small bone at the bottom of the spine) area. Review of Non-Pressure Skin Condition Record revealed on 5/21/24 the resident was admitted with several small, scattered areas of bruising to bilateral upper extremities and bruising to the resident's abdominal fold related to diabetic injections. Further review revealed no evidence the stage 1 pressure ulcer to the resident's coccyx area was assessed and/or the assessment documented. Review of a Nursing Progress Note dated 5/25/24 at 3:13 PM revealed the resident would at times call for the staff to put cream on the resident's buttocks because of discomfort to the area. Review of the resident's electronic medical record revealed no assessment was completed regarding the resident's buttocks/coccyx area. Review of a Weekly Skin Integrity Review dated 6/1/24 revealed the resident's skin was intact and no areas of redness or open areas were identified. Review of a Physician Visit Progress Note dated 6/4/24 revealed the resident was seen by the physician who ordered a consult with the Wound Care Clinic for the resident's coccyx pressure ulcer and a special cushion to be placed in the resident's wheelchair seat for pressure reduction. Review of a Weekly Skin Integrity Review dated 6/10/24 revealed the resident's skin was intact and no reddened or open areas were identified. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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	During an observation of wound care on 6/12/24 at 8:33 AM, Licensed Practical Nurse (LPN)-B completed hand hygiene and placed on clean gloves. LPN-B removed the Mepilex dressing to the resident's coccyx and identified the resident had an open area which measured approximately 1.5 centimeters (cm) by .2 cm. LPN-B confirmed this area was a stage 2 pressure ulcer (partial loss of skin presenting as a shallow open area). LPN-B sprayed normal saline on the ulcer and patted the area dry with clean gauze. LPN-B then placed a clean dressing on the area and applied a layer of barrier cream to the resident's reddened/excoriated buttock fold. During an interview on 6/12/24 at 9:00 AM, LPN-B confirmed the facility had been treating the resident's pressure ulcer since admission and staff were to complete weekly skin assessments on any pressure ulcers. LPN-B was uncertain as to when the pressure ulcer changed from a stage 1 to a stage 2 ulcer. Interview with the Director of Nursing (DON) on 6/12/24 at 1:10 PM revealed the resident had been admitted with a stage 1 pressure ulcer. The facility staff had failed to assess and to monitor the pressure ulcer and failed to identify when the ulcer progressed to the stage 2 pressure ulcer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 42360 Licensure Reference Number 175 NAC 12-006.18(B) Based on observation, record review and interview; the facility failed to maintain infection prevention measures for Enhanced Barrier Precautions (EBP-an infection control measure designed to reduce transmission of Multiple Drug Resistant Organisms (MDRO's-bacteria that have become resistant to certain antibiotics) during the provision of wound care for Residents 22 and 52, failed to implement EBP and best practice for catheter care to prevent potential infections for Resident 52, and failed to complete hand hygiene at appropriate intervals during the provision of care for Residents 22 and 52. The sample size was 20 and the facility census was 62. Findings are: A. Review of the facility policy Infection Prevention and Control Program with a revision date of 2/8/24 revealed the facility established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment, that helped to prevent the development and transmission of communicable diseases and infections, per accepted national standards and guidelines. In additional, all staff received training relevant to their specific roles and responsibilities, regarding the facilities infection prevention and control program, including policies and procedures related to their job functions. All staff demonstrated competency in relevant infection control practices and direct care staff demonstrated competence in resident care procedures established by the facility. B. Review of the facility policy Enhanced Barrier Precautions dated 5/16/23 with a revision date of 3/27/24 revealed the following: -The facility policy implemented EBP for the prevention of MRDO transmission of multidrug-resistant organisms. -Enhanced Barrier Precautions referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employed gown and gloves use, during high contact resident care activities. -All staff received training on EBP upon hire and at least annually and were expected to comply with all designated precautions. -All staff received training on high-risk activities and common organisms that require enhance barrier precautions. -The facility staff had discretion on how to communicate to staff which residents required EBP prior to high-contact care activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility had discretion in using EBP's for residents who did not have a chronic wound or indwelling medical device and were infected or colonized (presence of bacteria without causing disease) with a MRDO that was not currently targeted (resistant to all or most antibiotic/antimicrobial medications) by the Center for Disease Control (CDC). -EBP would be ordered for residents with chronic wounds such as pressure ulcers, diabetic foot ulcer/s, unhealed surgical wound/s, and chronic venous stasis ulcer/s (skin ulcer related to circulatory problems) and/or indwelling medical devices such as central lines, catheters, feeding tubes, or tracheostomy/ventilator tubes even for those residents not known to have MDRO's. -EBP were also ordered for infection or colonization with a CDC targeted MDRO when Contact Precautions (addition isolation precautions including the use of Personal Protective Equipment (PPE) worn by staff during the provision of care, taken to prevent the spread of infection) did not otherwise apply. -Implementation of Enhanced Barrier Precautions included, 1). gowns and gloves made available immediately near or outside resident rooms, 2). PPE for EBP did not have to be put on prior to entering resident rooms, 3). ensured access to alcohol-based hand rub in every resident room, and 4). positioned a trash can inside the resident room and near the exit for discarding PPE after removal, prior to exit of the room, or prior to providing care for another resident. -The facility Infection Preventionist (IP-qualified professional staff who make sure healthcare workers and patients do the things to prevent infection/s or the spread of infection) incorporated periodic monitoring and assessment of adherence, to determine the need for additional training and education, and provided education to residents and visitors for EBP. -High contact activities included bathing, dressing, transferring, providing hygiene, changing linens, toileting assistance (including changing briefs), device care or use (catheters, central lines, tube feedings, tracheostomies/ventilator tubes), and wound care. -EBP depended on local epidemiology (the study of who, where, and when patterns of health and disease occur) and were used during the duration of the affected person's stay in the facility, or until resolution or the wound or discontinuation of the indwelling medical device. C. Review of the facility policy Catheter Care with a revision date of 9/5/23 revealed the following: -The facility ensured residents with indwelling catheters received appropriate catheter care, and maintained their dignity and privacy when catheters were in use. -Urine drainage bags were kept below the level of the resident's bladder to discourage back-flow of urine. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	D. Review of the facility policy Using Isolation Personal Protective Equipment with a revision date of 12/7/23 revealed the following: -The primary purpose for implementing isolation procedures was to prevent the spread of infections from one individual to another and reduce the risk of infection in immunocompromised individuals. -When putting on a gown staff wrapped the gown around the back, secured the gown with the ties, and made sure their clothing was completely covered, and the gown was secure around the waist and neck. E. Review of the facility policy Hand Hygiene with a revision date of 2/8/24 revealed the following: -The facility performed proper hand hygiene procedures to prevent the spread of infections to other personnel, residents, and visitors. -Hand hygiene was a general term for cleaning your hands by washing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub. -Staff performed hand hygiene when indicated, using proper technique consistent with accepted standards of practice. -The use of gloves did not replace hand hygiene, and -hand hygiene was performed under the following conditions, including but not limited to when coming on duty,between resident contacts, after handling contaminated items including items potentially contaminated with body fluid, when moving from a contaminated to a clean body site, and before and after removing personal protective equipment including gloves. F. Review of Resident 52's Care Plan with a revision date of 3/25/24 revealed that the resident had a terminal condition, was dependent on the staff for toileting and hygiene needs including catheter care, had wounds that were not expected to heal and, EBP and had been initiated and were to remain in place due the presence of chronic wounds and a catheter. Staff were to apply appropriate precautions with high contact care activities. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of the provision of Care for Resident 52 On 6/11/24 at 1:33 PM Nurse Aid (NA-D) and Medication Aide (MA-C) retrieved gowns from a drawer just outside of the resident's room and entered the resident's room. NA-D immediately performed hand hygiene and put on the gown and gloves,and MA-C tucked the folded gown under an arm, performed hand hygiene and put on gloves. MA-C then approached the resident with the gown still off and applied a gait-belt (safety belt used to assist the resident during transfers and walking) around the resident's waist and brushed up against the resident's legs and clothing while no gown was in use. MA-C put on the gown securing it at the waist but not at the neck. NA-D and MA-C transferred the resident from a wheelchair to the bed. During the transfer MA-C's gown was gaping and falling off at the neck. NA-D handed the resident's catheter drainage bag to MA-C who lifted the bag approximately 2 feet above the resident before securing it the bedside. MA-C went to the bathroom and removed gloves, performed hand hygiene, re-secured the gown at the waist, and lifted it around the neck however leaving it unsecured at the neck. MA-C retrieved a graduate from the bathroom, went back to the bedside and lifted the catheter drainage bag waist high, observed the contents, placed the graduate container on the floor, knelt and emptied the urine from the bag. MA-C and NA- D assured the resident's comfort, removed their gowns and gloves, and hand sanitized. NA-D while not wearing gloves or a gown straightened and secured the resident's privacy curtain (brushing up against the curtain), secured the window curtain part way open, and picked up the resident's extra blanket, and folded it all the while the blanket touched NA-D's clothing. During an interview on 6/11/24 at 1:55 PM RN-E confirmed that staff should have gowns fully secured around the waist and neck, put the gown on prior to performing tasks such as applying a belt gait, and should not remove the gown until full contact with the resident or the resident's belonging is completed. Additional interview confirmed the staff were to keep catheter drainage bags at or below the level of the bladder at all times, to prevent urine from flowing back into the tubing and increasing the risk for infections. During an observation of the provision of wound care for Resident 52 on 6/13/24 at 7:29 AM RN-O entered the resident's room, performed hand hygiene, retrieved clean wrapped dressings from a dresser drawer, and put on gloves. RN-O greeted the resident and explained the plan to change the dressings on the resident's foot. RN-O removed a blanket from the resident's feet and placed a clean paper towel on bed and placed the clean dressings on the paper towel. RN-O used a bandage scissors and removed a dressing from the resident's left foot and discarded the dressing in the trash. RN-O removed the gloves and put on clean gloves without performing hand hygiene. RN-O cleansed a small wound on the lateral left foot and the left heel with wound cleanser and gauze. Again RN-O removed the gloves and put on clean gloves without performing hand hygiene. RN-O applied clean dressings to both the lateral foot and the left heel. Throughout the provision of care RN-O was not wearing a gown. During an interview on 6/13/24 at 7:40 AM RN-O revealed being aware that Resident 52 was on EBP, but forgot to wear a gown during the treatment of the resident's foot wounds. During an interview on 6/13/24 at 8:01 AM the Director of Nursing (DON) confirmed that staff are to hand sanitize between gloves changes and changing Resident 52's dressings involved high contact care and wearing a gown was required. In addition, the DON confirmed that staff are to keep urinary drainage bags below the level of the bladder at all times during care, to prevent potential backflow of urine and infection risk. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285102	A. Building B. Wing	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanton Health Center	301 17th Street Stanton, NE 68779

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	G. Review of Resident 22's Care Plan with a revision date of 4/19/24 revealed the resident had self-care deficits and a potential for impaired skin integrity due to dry scaly skin and edema (fluid retention within body tissue) and a history of picking at skin. During an observation of the provision of wound care on 6/13/24 at 7:17 AM RN-O entered Resident 22's room to complete dressing changes on the resident's lower legs. RN-O performed hand hygiene, retrieved clean dressings from the dresser, put on gloves, and removed edema wear (tight elastic sleeves used to treat edema and/or circulation problems of the lower extremities) from the resident's lower legs/feet. RN-O then removed one dressing from the right lower leg and one from the left lower leg using bandage scissors and discarded the dressings in a trash receptacle. RN-O removed the gloves and placed on clean gloves without performing hand hygiene. After cleaning the wounds with wound cleanser and gauze RN-O applied clean dressings and wrapped with clean gauze. RN-O removed the gloves, did not perform hand-hygiene, and re-applied the edema wear to both legs. During an interview on 6/13/24 at 8:01 AM the DON confirmed staff should always perform hand hygiene between wound sites and between gloves changes to prevent the potential spread of infection.