

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Emerald Nursing & Rehab Lakeview		STREET ADDRESS, CITY, STATE, ZIP CODE  1405 West Hwy 34 Grand Island, NE 68801	

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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49382</p> <p>Licensure Reference Number 175 NAC 1-009.01</p> <p>Based on observation and interview, the facility failed to ensure the facility was neat clean and in good repair. This affected 11 of 69 facility residents. Facility stated a census of 69.</p> <p>Findings are:</p> <p>On 12/02/2024 a walk through was completed from 10:00 AM to 10:32 AM where the following was observed.</p> <ul style="list-style-type: none"> <li>-Cobwebs with debris visible in the windows of the Activities room of the secured care unit.</li> <li>-Chipped and peeling paint exposing unsealed wood on the door frames of resident rooms 411, 404, 405, 403, 207, 209, 102, 107, 108, and room [ROOM NUMBER].</li> <li>-Missing light fixture cover on a light located in the ceiling of the Activities room on the secured unit.</li> <li>-In room [ROOM NUMBER] bathroom [ROOM NUMBER] pieces of material in different shades of white attached with black screws to the ceiling surrounding the vent located in the ceiling of the bathroom.</li> <li>-In the hallway of the secured care unit inside of the main double doors multiple pieces of white material secured to the ceiling with writing on them. One piece of the material on the edge is wavy and warped not fully secured to the ceiling.</li> <li>-A wooden rocking chair in the Activities Room on the secured unit with out cushion to the seat of the rocking chair exposing the brown cloth material that is frayed and not secured to the frame of the rocking chair.</li> </ul> <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>An interview on 12/04/2024 at 1:26 PM with the Facility Administrator (FA), confirmed that the paint was peeling and chipped from the door frames of the rooms listed, the areas in the ceiling of room [ROOM NUMBER] and the secured care unit hall were not sealed appropriately, there was no cushion to the rocking chair, and cobwebs with debris were present in the window of the Activities room of the secured unit. The FA confirmed that there was no current written action plan to address the repair, cleaning, or maintenance of these areas of soiling and disrepair.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>51560</p> <p>Licensure Reference Number 175 NAC 12-006.09</p> <p>Based on observation, interview, and record review, the facility failed to provide an assessment by a licensed professional nurse for 1 (Resident 23) of 1 sampled residents with symptoms of a potential respiratory infection. The facility identified a census of 69.</p> <p>Findings are:</p> <p>A record review of Resident 23's Order Summary dated 12/2/24 reveal diagnoses of Allergic Rhinitis (an allergic reaction that causes sneezing, congestion and sore throat) entered on 06/08/23 and Chronic Sinusitis (an inflammation of the sinus or nasal passages occurring for more than 12 weeks at a time) entered on 07/25/24. The Order Summary dated 12/2/24 also revealed an order entered on 10-16-2024 for Mucinex (a medication that helps loosen congestion in the chest and throat, making it easier to cough out through the mouth) for the indication of cough. Instructions for the medication stated the medication should be administered as needed twice a day. The order did not include a stop date.</p> <p>A record review of Medication Administration Record (MAR) for the month of November 2024 revealed that Resident 23 received Mucinex 22 days out of 30. The MAR revealed that Mucinex was administered and followed up for effectiveness each time by a Medication Aide.</p> <p>Record review of Resident 23's progress notes revealed no documentation of respiratory assessments or nursing attention being directed towards Resident 23's cough.</p> <p>An observation on 12/2/24 at 3:35 PM in Resident 23's room revealed Resident 23 to be lying in bed with the head of the bed elevated approximately 30 degrees. Resident 23 was noted to have a cough that sounded deep and productive (producing mucus).</p> <p>An interview with Resident 23 on 12/2/24 at 3:35 PM revealed that the cough had been present for a while, however, within the last two weeks it had worsened. Resident 23 states that they made nursing staff aware of its worsening but was unable to recount the names of staff members notified. Resident 23 revealed that [gender] stay mostly in bed, including meals, and gets out of bed two-three times a day for toileting purposes. Resident 23 revealed [gender] take walks approximately four times a week with the restorative aide.</p> <p>An interview with LPN-H (Licensed Practical Nurse-H) on 12/04/24 at 9:57 AM revealed LPN-H was aware Resident 23 had a cough but was unaware Resident 23 had concerns about cough worsening. LPN-H confirmed that they are the full-time day shift nurse for Resident 23 and states [gender] were not notified that the Medication Aide was administering the as needed Mucinex and performing a follow-up on the medication's effectiveness. LPN-H confirmed that there had not been a respiratory assessment completed by a nurse.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with DON (Director of Nursing) on 12/04/24 at 10:52 AM confirmed that there was no policy on what as needed medications should be followed up by the nurse as opposed to the Medication Aide. The DON confirmed there was no policy detailing procedures for performing focused assessments related to acute conditions. The DON confirmed it is best practice to perform focused assessments for acute symptoms or conditions. The DON stated resident does have diagnosis of chronic sinusitis but confirmed that Mucinex was ordered for an indication of cough, which Resident 23 did not have a chronic diagnosis for.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>51560</p> <p>Licensure Reference Number 175 NAC 12.006.09(H)(iii)(2)</p> <p>Based off observation, interview, and record review, the facility failed to routinely assess a pressure ulcer (a localized area of damaged skin or tissue that can occur when pressure is applied to an area for a prolonged period) and monitor the effectiveness of the treatment for the wound for 1 (Resident 26) of 1 sampled residents. The facility identified a census of 69.</p> <p>Findings are:</p> <p>A record review of Resident 26's Minimum Data Set (MDS, a federally mandated tool used to assess the health of nursing home residents who are enrolled in Medicare or Medicaid) dated 10/30/24 revealed that Resident 26 was fully dependent on nursing staff for all activities of daily living (ADLs). The MDS further revealed a diagnosis of Pressure Ulcer of Other Site, Unspecified.</p> <p>A record review of Resident 26's Order Summary dated 12/4/24 revealed the following diagnoses: Spastic Quadriplegic Cerebral Palsy; Contractures of Muscle, Right Upper Arm; Other forms of Scoliosis, Lumbar Region; Contractures of Muscle, Left Upper Arm; Severe Intellectual Disabilities; Contractures of Right Knee; Contractures of Left Knee; Pressure Ulcer of Other Site, Unspecified Stage.</p> <p>A record review of Resident 26's Order Summary dated 12/4/24 revealed the following orders regarding wound care:</p> <p>-An order dated 6/13/24: To right knee wounds, remove old dressings and wash areas with warm soapy water. Rinse and pat dry or cleanse with saline and pat dry, then apply Derma blue cut to fit. Cover with an abdominal pad. Secure with Kerlix and tape. Change three times per week on bath days; one time a day every Tuesday, Thursday, and Saturday for wounds.</p> <p>-An order dated 11/15/24: Nursing Order Wound care of Left Foot, 1st toe: Apply skin prep to area and cover with silicone foam dressing. Apply skin prep and change foam dressing every Tuesday, Thursday, and Saturday for Fluid Filled Blister of Left Foot, 1st toe.</p> <p>-An order entered on 5/6/24: Weekly Skin Assessment, please complete weekly skin integrity review V1 on Bath Day every day shift every Sat for Skin integrity.</p> <p>A record review of Weekly Skin Assessment for the month of November 2024 revealed no wound descriptions or measurements.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of a wound consultation with a wound care clinic dated 11/1/24 revealed that Resident 26's wounds were followed by the clinic and Resident 26 was seen once a month. Consult revealed diagnosis of Skin Ulcer of right knee with fat layer exposed (HCC). The providers documentation revealed I do have some concerns today with the right medial knee ulceration measuring slightly larger with some seropurulent drainage (a type of wound drainage that can be a sign of infection or inflammation). I am going to go ahead and start Resident 26 on oral antibiotics for cellulitis of this wound. Document further describes Open wound to medial knee is covered in 100% red moist tissue with moderate amount of seropurulent drainage noted. The Provider's measurements of the wound were 1.8 x 2.5 x 0.1.</p> <p>An interview with Director of Nursing (DON) on 12/5/24 at 8:26 AM revealed that the facility expectation was that nurses are responsible for obtaining wound measurements and descriptions during the Weekly Skin Assessment. DON confirmed that wound measurements and descriptions were not being documented on skin assessment days or at any other time other than monthly with wound care nurse.</p> <p>A record review of the facility policy titled Skin and Wound Management dated 1/2024 revealed that the nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers. In addition, the nurse shall describe and document/report the following: full assessment of pressure sore including location, stage, length, width, depth, and presence of exudates or necrotic tissue.</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 51560</p> <p>Licensure Reference Number 175 NAC 12-006.09(h)(v)</p> <p>Based on observation, interview, and record review, the facility failed to implement interventions to prevent the potential worsening of a contractures for 1 (Resident 23) of 1 sampled resident. The facility identified a census of 69.</p> <p>Findings are:</p> <p>A record review of Resident 23's face sheet dated 12/2/24 revealed an admitted [DATE] and a diagnosis of contractures, (a permanent tightening of the muscles, tendons, skin, or nearby tissues that limits the range of motion of a joint or body part) of the left hand was added on 06/08/23.</p> <p>A record review of the undated Care Plan revealed no documentation for a contractures of the left hand or interventions for the contractures.</p> <p>A Record review of Resident 23's admission Minimum Data Set (MDS, a federally mandated tool used to assess the health of nursing home residents who are enrolled in Medicare or Medicaid) dated 04/22/2021 revealed no documentation of a contractures.</p> <p>A Record review of MDS dated [DATE] revealed no documentation of a contractures. The MDS did reveal Resident 23 requires partial to moderate assistance from staff with all activities of daily living.</p> <p>An observation on 12/2/24 at 3:35 PM in the room of Resident 23 revealed a contractures of the Resident's left hand in which four of five fingers were noted to be bent inwards towards the palm. Fingernails were untrimmed with the tips of fingernails touching the skin of the Resident's palm.</p> <p>An interview with Resident 23 on 12/2/24 at 3:35 PM revealed that the contractures was present prior to admission and caused pain, discomfort and interfered with activities of daily living. Resident 23 revealed the facility staff do not provide assistance with cleaning under fingers or placing towel roll in between fingers and palm.</p> <p>An interview with Occupational Therapist (OT) on 12/04/24 at 9:07 AM revealed Resident 23 received services from 03/18/22 to 04/11/22. Services were discontinued because Resident 23 reached their maximum potential with skilled services.</p> <p>Record review of the OT Discharge Note dated 04/11/22 revealed that Resident 23 was unable to tolerate range of motion (ROM) exercises however was able to complete gentle self-stretching exercise of left hand. The Discharge Note also revealed that Resident 23 is unable to tolerate splint, however, is able to keep small towel roll as barrier in left hand. The Discharge Note revealed that Resident 23 and caregiver (nursing home staff) training included exercise program, compensatory strategies, self-care/skin checks, and splinting/orthotic schedule.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the Director of Nursing (DON) on 12/04/24 at 8:55 AM confirmed that Resident 23 did receive services from OT in 2022 and did receive Botox (a nerve blocking medication that prevents muscles from contracting) injections in 01-2024 to assist with both pain and range of motion of fingers. Injections were not successful and Resident 23's financial power of attorney did not wish to continue treatment. The DON confirmed that the facility implemented no further interventions after that point including self-care or rolled towel to palm intervention.</p> <p>A Record review of the facility ADL policy revised 1/2024 revealed: the facility will maintain individual objectives of the care plan and periodic review and evaluation</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>49382</p> <p>Licensure Reference Number 175 NAC 12-006.10 (D)</p> <p>Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% with an observed medication error rate of 7.41% (27 administrations and 2 errors). This affected 2 (Residents 14 and 17), of 10 sampled residents. The facility stated census of 69.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of a facility policy titled Clinical Management Medication Administration dated 05-2017 revealed to verify the pharmacy prescription label on the drug and the medication administration record or the physician orders. If there is a discrepancy check the original physician order and notify the pharmacy do not give the medication until clarified.</p> <p>In an observation completed on 12/03/2024 at 12:15 PM Medication Aide G, (MA-G), obtained a box labeled with Resident 17's name and Ultra Eye Preservative Free Drop 0.4-0.3% with directions to instill one drop into both eyes every 2 hours as needed for dry eyes. MA-G then proceeded to administer the eye drop to Resident 17.</p> <p>In an interview on 12/03/24 12:32 PM with MA-G, MA-G stated that the resident received the eye drop on a routine basis and not on an as needed basis. The MA confirmed that the label read for the eye drop to be administered on an as needed basis not routinely.</p> <p>Record review of Resident 17's Medication Administration Record dated 12/03/24 revealed a physician order for Ultra Eye Preservative Free Drop 0.4-0.3% with directions to instill one drop into both eyes four times a day.</p> <p>In an interview on 12/03/2024 at 1:05 PM with the Director of Nursing (DON) confirmed that Resident 17's Ultra Eye Preservative Free Drop 0.4-0.3% label read to administer the eye drop every 2 hours as needed and the physician order read to administer the eye drop four times a day. The DON confirmed that the physician order and the label did not match.</p> <p>B.</p> <p>In an observation completed on 12/03/2024 at 12:30 PM MA-G obtained a white tube of medication labeled Diclofenac Gel 1% apply 4 GM (Grams) to knees four times daily. MA-G walked to Resident 14's room, knocked on the door, acknowledged the resident and then entered the resident's room. The MA informed Resident 14 they were going to apply the residents pain cream and asked the resident if they would like the cream applied to their back or their knees. Resident 14 stated they would like the cream applied to their back. The MA then applied the gel to the resident's back.</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>Record review of Resident 14's Medication Administration Record dated 12/03/2024 revealed that Resident 14 had a physician order for Diclofenac Gel 1% to apply 4 Grams to the knees four times a day.</p> <p>In an interview on 12/03/2024 at 12:32 PM with MA-G, MA-G confirmed that the label on the tube of medication read for the gel to be applied to the residents knees and the physician order read for the gel to be applied to the resident knees and that the order did not reflect that the gel was to be applied to the residents back or knees per the residents choice.</p> <p>In an interview on 12/03/2024 at 1:05 PM with the DON confirmed that Resident 14 did not have an order for Diclofenac Gel to be applied to their back. The order only indicated it was to be applied to the resident's knees. The DON confirmed that the gel should only be applied as directed in the order.</p>

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<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>50253</p> <p>License Reference Number 175 NAC 12-006.11</p> <p>Based on record review, observation, and interviews, the facility failed to ensure the menus were followed as written and that use of the correct size serving spoons were used when meals are served resulting in less than required caloric intake. This affected 13 (Residents 40, 65, 22, 223, 6, 54, 44, 49, 43, 221, 222, 55, and 59) of 15 residents served meals. The facility census was 69.</p> <p>Findings are:</p> <p>An interview on 12/02/2024 at 8:00 AM with the facility [NAME] reveled the cook reviewed the menu for the week. The cook also took the time to discuss the serving spoons that are used in the facility when serving meals. The serving spoons all had different colors and were in separate containers by serving size. The 8 ounce serving spoons were stored together and were orange and green in color.</p> <p>Record review of the Menu titled Dietary Spreadsheet for week 3 used by the dietary department for meal planning. The document copyright date was 2024. The meal served at noon on 12/03/2024 was scheduled for Day 17 and included the following items:</p> <ul style="list-style-type: none"> <li>-Chicken pot pie - 8 ounces</li> <li>-Lima Beans - 4 ounces</li> <li>-Peanut butter cookie - 2 cookies</li> <li>-Beverage - 8 ounces</li> </ul> <p>An observation on 12/03/24 at 12:10 PM revealed food from the kitchen was delivered to the 500 hallway by Dietary Aide (DA-B) on a steam table to serve the individual residents who requested room trays. Chicken Pot pie was served with a white 6-ounce scoop. Each residents plate had one cookie served on a single plate.</p> <p>An interview on 12/03/2024 at 12:36 PM with DA-B revealed that the white scoop was used to serve meals as that is what had been provided in plastic wrap to serve the meals.</p> <p>An interview on 12/03/24 at 12:38 The facility [NAME] confirmed a white 6-ounce scoop was used by the dietary personnel to serve the chicken pot pie during the noon meal.</p>		

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50253</p> <p>License Reference Number 175 NAC 12-006.119(A)(iv)</p> <p>Based on record reviews, observations, and interviews, facility failed to provide a physician ordered therapeutic diet with increased protein for 1 (Resident 22) of 1 resident sampled. The facility census was 69.</p> <p>Findings are:</p> <p>Record review of the Minimum Data Set (MDS, a standardized assessment tool used to comprehensively evaluate the health and functional capabilities of residents and for use when creating Care Plans) dated 11/10/24 for Resident 22 revealed the resident had a Brief Interview of Mental Status (a short cognitive screening tool used to assess a person's mental abilities in long-term care facilities) score of 14 a score of 13 to 15 means the individual is cognitively intact.</p> <p>Record review on 12/03/24 of the working Care Plan (a document outlining a resident's individual healthcare needs, including medical conditions, personal preferences, and specific care strategies to provide the best possible support and treatment) revealed that Resident 22 was admitted on [DATE], had diagnoses of non-pressure ulcer of the back with necrosis of the bone, pressure ulcer of the sacral region stage 4, severe protein-calorie malnutrition, type 2 diabetes, anemia, and paraplegia. The care plan also revealed that Resident 22 had a nutritional problem related to non-pressure chronic back ulcer, pressure ulcer of the sacral region stage 4, severe protein-calorie malnutrition and anemia. Supplements were to be to be given as ordered.</p> <p>Record Review of the Physician Orders printed on 12/04/2024 revealed dietary orders that Resident 22 was to receive a regular diet, regular texture, regular consistency with double portions of proteins with meals as well as snacks and supplements per the registered dietician's recommendations.</p> <p>Observation on 12/04/24 at 12:10 PM of Dietary Aide (DA-B) who served the resident meals to those who resided on the 500 hallway. DA-B served Resident 22 one scoop of meat and one sandwich to Resident 22.</p> <p>Interview on 12/04/24 at 12:30 PM with DA-B, who stated Resident 22 received two sandwiches instead of just one. Retrieved the dining room meal order ticket to show that Resident 22 is ordered to receive double protein servings.</p> <p>Interview on 12/04/24 at 12:55 PM with Resident 22 revealed Resident 22 that only one sandwich and one portion of protein was served with the noon meal.</p> <p>Interview on 12/04/24 at 12:57 PM with Activity Aide (ACT-A) who repeated the question to Resident 22 for clarification as Resident 22 only speaks Spanish. Resident 22 stated [gender] had uno (one) sandwich and held up one finger. Confirmation from ACT-A that Resident 22 had only one portion of protein during the noon meal.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285106	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/05/2024
NAME OF PROVIDER OR SUPPLIER  Emerald Nursing & Rehab Lakeview		STREET ADDRESS, CITY, STATE, ZIP CODE  1405 West Hwy 34 Grand Island, NE 68801	

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

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<p>F 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 12/04/24 at 01:00 PM with the Administrator confirmed Resident 22 has an order for double protein servings at meal time.</p> <p>Interview on 12/04/2024 at 01:15 with DA-B revealed that Resident 22 had not been given the double servings of protein but instead another resident.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>41938</p> <p>Licensure Reference Number 175NAC 12-006.19(C)(i)</p> <p>Licensure Reference Number 175NAC 12-006.18(B)</p> <p>Based on observation, interview, and record review, the facility failed to ensure that staff performed laundry delivery to residents in a manner to prevent the potential for cross-contamination for 20 of 20 residents observed (Residents 57, 10, 15, 26, 7, 27, 37, 11, 30, 36, 31, 223, 22, 54, 6, 60, 59, 43, 55, and 41). The facility census was 69.</p> <p>Findings are:</p> <p>Record review of the facility Infection Prevention and Control Program dated 5/20/17 revealed that the facility will establish and maintain an infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections. Laundry and direct care staff will handle, store, process, and transport linens so as to prevent the spread of infection. The section titled Hand Hygiene Protocol revealed that all staff shall wash their hands between resident contacts and after handling contaminated objects.</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 - Some</p>	<p>Observation on 12/3/24 at 1:38 PM on the facility 300 hall revealed that Laundry Aide-D (LA-D) removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 14. LA-D exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-D did not perform hand sanitization. LA-D removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 57. The clothing was held rubbing against the front of the emerald green uniform of LA-D. LA-D exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-D did not perform hand sanitization. LA-D removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 10. LA-D exited the resident room and returned to the laundry cart. LA-D did not perform hand sanitization. LA-D removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 15. LA-D exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-D did not perform hand sanitization. LA-D removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 26. LA-D exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-D did not perform hand sanitization. LA-D removed clothing on hangers from inside the laundry cart and carried them to the closed room door of Residents 7 and 27 (roommates). The clothing rubbed against the front of the uniform of LA-D. An unidentified staff cracked open the door and told LA-D that they were working with a resident in the room. LA-D carried the clothing back to the laundry cart and placed the clothing back inside the laundry cart. LA-D removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 37. The clothing rubbed against the front of the uniform of LA-D. LA-D exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-D did not perform hand sanitization. LA-D removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 11. LA-D exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-D did not perform hand sanitization. LA-D removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 30. LA-D exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-D did not perform hand sanitization. The time was now 1:45 PM. This surveyor asked LA-D if they are to do any sanitization between resident rooms. LA-D responded yes. LA-D did not perform hand sanitization. LA-D removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Residents 36 and 31 (roommates). LA-D exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-D did not perform hand sanitization.</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 - Some</p>	<p>Observation on 12/4/24 at 3:47 PM on the facility 500 hall revealed that Laundry Aide-E (LA-E) pushed the covered laundry cart onto the 500 hall. LA-E removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 44. LA-E exited the resident room and returned to the laundry cart. LA-E did not perform hand sanitization. LA-E removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Residents 223 and 22 (roommates). LA-E exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-E did not perform hand sanitization. LA-E removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 54. LA-E exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-E did not perform hand sanitization. LA-E removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 6. LA-E exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-E did not perform hand sanitization. LA-E removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Resident 60. LA-E exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-E did not perform hand sanitization. LA-E removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Residents 59 and 43 (roommates). LA-E exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-E did not perform hand sanitization. LA-E removed clothing on hangers from inside the laundry cart and carried the clothing into the room of Residents 55 and 41 (roommates). LA-E exited the resident room carrying used empty clothes hangers and placed them inside the laundry cart. LA-E did not perform hand sanitization. This surveyor asked LA-E if they are to do any sanitization between resident rooms. LA-E responded that they are to use the hand sanitizer after coming out of each room. LA-E did not perform hand sanitization. LA-E opened the laundry cart and began to rearrange a blanket and linens on the bottom shelf of the laundry cart.</p> <p>Interview with the facility Director of Nursing (DON) on 12/5/24 at 1:03 PM confirmed that the expectation is for all facility staff to perform hand sanitization after exiting a resident's room to prevent cross contamination.</p> <p>Interview with the facility Infection Preventionist (IP) on 12/5/24 at 1:03 PM confirmed that staff should not carry clothing or laundry against their uniform due to the potential for cross contamination.</p>		