| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 285124 | A. Building<br>B. Wing | 03/25/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Arbor Care Centers-Neligh LLC | 1100 T Street<br>Neligh, NE 68756 |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>51391<br><br>Licensure Reference Number 175 NAC 12-006.19<br><br>Based on observations, record review and interview; the facility failed to ensure mechanical lifts were maintained in a manner to promote resident safety. This has the potential to affect all residents who utilized mechanical lifts. In addition, the facility failed to ensure the wall, curtain, light cover and bathroom door frame were maintained in good repair in room C11, maintain the cleanliness of the bathroom ceiling ventilation covers, maintain the door frames to the resident's room and bathrooms to be free of chipped paint to 29 rooms ( C5 to C14, D15 to D27, B30 to B530) and maintain the cleanliness and condition of bathroom floors in room C11 and D25. The sample size was 19 and the facility census was 33.<br><br>Findings are:<br><br>A. Review of the Facility Assessment Tool with a revision date of 1/27/25 revealed the facility conducted an annual review of their resident population and the resources the facility needed to care for their residents. The purpose of the assessment was to determine what resources were necessary to care for residents competently during both day-to-day operations and emergencies. The facility ensured equipment was maintained to protect and promote the health and safety of residents including lifts (lifting devices). Equipment and/or devices were inspected annually or replaced/repaired if they presented a hazard. The maintenance and nursing staff ensured adequate supplies or equipment for resident care. Maintenance staff were to perform inspections of the property and building.<br><br>B. Review of the facility policy Safe Resident Handling/Transfers dated 12/5/23 revealed the following:<br><br>-It was the policy of the facility to ensure that residents were handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines.<br><br>-All residents required safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them.<br><br>(continued on next page) |

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

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

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -Mechanical lifting equipment or other approved transferring aides were used based on resident need.<br><br>-Staff inspected equipment prior to use to ensure functionality and alerted maintenance or designee if the equipment was not functioning properly.<br><br>-Damaged, broken, or improperly functioning lift equipment was not used and tagged out according to facility policy.<br><br>C. Review of the facility policy Preventative Maintenance Program dated September 2024 revealed the following:<br><br>-The Maintenance Director was to develop and maintain a schedule of services to ensure that the building and equipment were maintained in a safe and operable manner.<br><br>-The Maintenance Director was to assess all areas of the building to determine if maintenance was required.<br><br>-If maintenance was required, the Maintenance Director should decide what tasks need to be completed and how often to complete them.<br><br>-Tasks completed would be documented on a calendar.<br><br>-Documentation should be completed for all tasks and kept in the Maintenance Director's office for at least 3 years.<br><br>D. During an interview on 3/18/25 at 10:15 AM with responsible party of Resident 15, a concern was brought up in regard to the wall in room C11 being gouged, scraped and missing paint and the curtain liner hanging lower the curtain.<br><br>Observation of resident rooms during the initial pool on 3/18/25 from 10:30 AM to 2:30 PM revealed the following:<br><br>-Resident room C11 had a 21 centimeter (cm) by 16 cm area with paint peeled away with scrapes and gouges in the drywall. The curtain in the room had the inner lining hanging lower than the curtain and there was a large hole in the light cover over the resident bed.<br><br>-Ventilation covers were coated with a collection of a dark fuzzy substance which resembled dust in bathrooms of rooms C5 to C14, D15 to D27, and B38 to B53.<br><br>-Door frames to the resident rooms and bathrooms had chipped and peeling paint to the bottom 1/3 of the doors, rooms C5 to C14, D15 to D27 and B38 to B53.<br><br>-The bathroom in room D25 had cracked flooring around the toilet and the tile was stained a dark brown color.<br><br>(continued on next page) |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | -The bathroom in room C9/C11 had stained tile, black in color, surrounding the toilet, the threshold going into the bathroom from room C9 and C11 was missing chunks of tile. The lower 1/3rd of the door frame to room C11 was the color of a brown substance with a rust like appearance, the base of the door frame was missing a piece of the door frame with a sharp splintered edge measuring 8cm by 2.5 cm.<br><br>During an interview on 3/20/25 at 1:30 PM the Housekeeping Supervisor confirmed that the ventilation covers in the resident bathrooms are not being cleaned.<br><br>During an interview on 3/20/25 at 2:30 PM the facility Maintenance Director and the interim Director of Nursing (DON) confirmed that they were unaware of the condition to the wall, curtain and bathroom in room C11 and the bathroom in room D25. The Maintenance Director and the interim DON confirm that the wall, light cover, curtain and bathroom in room C9/C11 need to be fixed, the bathroom floor in room D23 needs to be fixed and the door frames to the rooms and bathroom need to be painted.<br><br>E. During an observation of the provision of care for Resident 3 on 3/20/25 at 11:24 AM Nurse Aides (NA)'s J and N entered the resident room to assist the resident to the commode. Both NA's put on gowns and gloves, placed a lifting sling under the resident and proceeded to transfer the resident to the commode using a full body mechanical lift. During the lifting process the mechanical lift stopped abruptly, and the NA's had to utilize the emergency switch to lower the lift. The NAs were unable to get the lift to function even after retrieving a fresh battery.<br><br>During an interview on 3/20/25 at 11:51 AM NA -N confirmed having routinely struggled with the mechanical lifts used in the facility. NA-N further reported staff have to routinely stop in the middle of a task and replace a battery, and sometimes that doesn't even work.<br><br>During an interview on 3/20/25 11:55 AM Resident 3 confirmed staff daily have to try multiple things just to get the facility lifts to work as intended when they are completing cares.<br><br>During an interview on 3/20/25 at 12:00 PM the interim DON confirmed nursing staff had reported problems with the facility mechanical lifts working consistently, and/or the batteries working consistently, however was not aware of a long-term solution to ensure the facility lifts were being maintained to ensure care delivery was safe and consistent.<br><br>During an interview on 3/25/25 at 9:50 PM the facility Maintenance Director confirmed being aware of the facility mechanical lifts were not consistently functioning despite the facility replacing the removable lift batteries, however the lifts also have attached power boxes that the batteries hook to and a request to replace those had not been approved. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638<br><br>LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D7 (b)<br><br>Based on observations, interviews, and record review; the facility failed to implement fall interventions, and to develop and/or revise fall interventions for the prevention of ongoing falls for Residents 5, 15 and 19. The sample size was 4 and the facility census was 33.<br><br>Findings are:<br><br>A. Review of the facility policies Fall Prevention Program and Fall Risk Assessment with revision dates of 9/24 revealed at the time of admission, a Fall Risk Assessment was to be completed to determine a resident's risk for falls. The Fall Risk Assessment was then to be completed quarterly, annually and with any significant change in condition. If the resident were determined to be at risk for falls, a care plan would be created to address each item identified on the risk assessment and updated accordingly. The at-risk care plan would include interventions, including adequate interventions consistent with the resident's needs and goals to reduce the risk of an accident. The staff were to monitor the effectiveness of the care plan interventions and modify the interventions, as necessary.<br><br>B. Review of Resident 5's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 2/6/25 revealed the resident was admitted [DATE] with diagnoses of pneumonia, atrial fibrillation, heart failure, arthritis, non-Alzheimer's dementia, Parkinson's disease, anxiety, depression, bipolar disorder and morbid obesity. The following was assessed for the resident:<br><br>-cognition was moderately impairment.<br><br>-frequently incontinent of bladder.<br><br>-dependent for personal hygiene, dressing, transfers, toileting hygiene and bed mobility.<br><br>-functional limitation of range of motion to bilateral lower extremities.<br><br>-use of chair alarm daily.<br><br>Review of the Resident 5's current Care Plan dated 9/5/24 revealed the resident was at risk for falls related to poor balance and the need for assistance with transfers. Nursing interventions with development dates included the following:<br><br>-9/5/24 allow the resident privacy but do not leave unattended and alone on the commode or in the bathroom.<br><br>-9/6/24 resident to wear non-skid footwear when up and out of bed.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -9/6/24 do not leave the resident unattended and alone while seated in the wheelchair in the resident's room. Assist to the recliner or into bed before leaving the room.<br><br>-9/9/24 Tabs alarm (personal alarm with a pull string that attaches magnetically to the alarm with a garment clip to the resident. When the resident attempts to rise, the pull string magnet is pulled away from the alarm which causes the alarm to sound) to alert staff when the resident attempts to transfer without assistance. Staff to check placement and function each shift.<br><br>-9/10/24 Dycem (non-slip material) pad to the seat of the resident's recliner.<br><br>-10/4/24 each time staff walks by the resident's room to check and to monitor for safety in positioning in bed and chair.<br><br>-10/14/24 the evening shift to toilet the resident before they leave at 10:00 PM.<br><br>Review of an Incident Report dated 1/9/25 at 6:00 AM revealed the resident was found on the floor next to the resident's bed. The resident's bed was in the lowered position, but the resident's Tabs alarm was not in place. Review of a staff meeting held 1/9/25 revealed the nursing staff were educated on ensuring all resident's fall alarms were functional and in place before leaving the resident rooms.<br><br>Review of an Incident Report dated 1/20/25 at 4:00 AM revealed the resident was observed on the floor next to the resident's bed. An intervention was identified to make sure the bed controls were not in reach for the resident as the resident was unable to utilize safely.<br><br>Review of an Incident Report dated 1/22/25 at 2:22 PM revealed the resident was transferred to the bath chair by the bath-aide. The staff failed to secure the bath chair safety belt and started to undress the resident. The resident leaned forward and then fell out of the bathchair. Staff were educated to secure the seat belt on the bathchair before starting to work with the resident. Further review revealed no documentation as to the education provided or to the staff who received the education. No further interventions were developed and current interventions were not reviewed and/or revised.<br><br>Review of an Incident Report dated 2/14/25 at 6:45 AM revealed the resident was found seated on the floor next to the resident's bed. The bed was in the lowered position and the resident identified sliding off the edge of the bed.<br><br>Review of a Post Fall Evaluation dated 2/14/25 at 10:31 AM revealed the resident's Tabs alarm was not sounding when the resident was found on the floor. An intervention was developed for non-slip strips to be placed on the floor next to the resident's bed. Further review of the assessment revealed no evidence staff addressed the resident's fall alarm not functioning.<br><br>Review of an Incident Report dated 2/23/25 at 2:25 AM revealed the resident's fall alarm was sounding and the resident was found on the floor in the resident's room next to the bed. At the time of the fall the resident was wearing gripper socks. An intervention was identified for a fall mat next to the resident's bed to prevent or to lessen injuries related to a fall.<br><br>Observations of Resident 5 revealed the following:<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -3/18/25 at 11:20 AM the resident was seated in the wheelchair in the corridor outside of the dining room. The resident had a Tabs alarm box attached to the back of the chair, however, the pull string and garment clip was hanging down the back of the chair and was not attached to the resident and/or their clothing.<br><br>-3/18/25 Nurse Aide (NA)-G approached the resident from behind and clipped the string of the fall alarm to the back of the resident's clothing. NA-G stated, I guess I forgot to attach your alarm.<br><br>-3/18/25 from 1:45 PM to 2:15 PM the resident was seated in the wheelchair alone and unsupervised in the resident's room.<br><br>-3/20/25 at 9:25 AM the resident's bathroom call light was activated. NA-G opened the bathroom door and revealed the resident was attached to the mechanical lift and was alone and unsupervised, seated on the toilet.<br><br>-3/20/25 from 9:37 AM to 11:40 AM the resident remained in the resident's room while seated in the wheelchair. The resident was alone and unsupervised throughout this time.<br><br>Interview with NA-G on 3/20/25 at 11:45 AM revealed the resident was at risk for falls and was to always have a Tabs alarm on when up in the wheelchair. NA-G was unaware of interventions for the resident to be supervised when alone in the wheelchair in the resident's room or when in the bathroom but confirmed most of the resident's falls occurred when the resident was attempting to self-transfer.<br><br>During an interview on 3/20/25 at 2:49 PM, the Interim Director of Nursing (DON) confirmed the resident's Care Plan identified the resident was not to be left alone and unsupervised in the resident's room when seated in the wheelchair or when in the bathroom. The resident was a high risk for falls and continued to self-transfer despite repeated directions to use the call light and to call for staff assistance. The following was also confirmed:<br><br>-Tabs alarm was to always be on the resident when up in the wheelchair and/or recliner.<br><br>-the Charge Nurses were to complete an Incident Report at the time of each fall with identified causal factors and a new intervention. The fall interventions should be related to the causal factors to prevent further falls. Reports should include implementation of current interventions in place at the time of the falls.<br><br>-staff re-education should be documented as to when it occurred, what education was provided and which staff received if this was identified as a fall intervention.<br><br>C. Review of Resident 19's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of Alzheimer's disease, non-Alzheimer's dementia, depression, and osteoporosis. The following was assessed for the resident:<br><br>-cognition was moderately impairment.<br><br>-frequently incontinent of bowel and bladder.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -substantial for dressing, transfers, and toileting hygiene.<br><br>-use of a motion sensor alarm daily.<br><br>Review of the resident's current Care Plan dated 9/18/24 revealed the resident was at risk for falls related to Alzheimer's disease, impaired safety awareness and need for assistance with transfers. Nursing interventions with dates the interventions were developed included the following:<br><br>-9/18/24 make sure the resident's room was free of clutter and the resident's bedspread was not touching the floor.<br><br>-9/18/24 make sure the resident's bed was always in the normal position except during active cares.<br><br>-9/18/24 to wear non-skid footwear unless wearing shoes.<br><br>-9/18/24 Make sure the resident's walker was always safely within reach.<br><br>Review of an Incident Report dated 12/1/24 at 10: 40 PM revealed the resident was found on the floor of the resident's room in front of the electric lift recliner. The recliner was in the highest position. The resident identified trying to fix the lights on a nearby Christmas tree. The resident was encouraged to use the call light to seek staff assistance when needed. An intervention was identified to speak to the staff tomorrow to see of the resident's room could be rearranged so the Christmas tree was less accessible to the resident. In addition, a video camera was placed in the room with the monitor positioned at the Nurse's Station so the staff would be able to observe the resident more closely.<br><br>Review of a Progress Note dated 12/2/24 at 3:40 AM revealed the resident had an unwitnessed fall in the resident's room when reaching for a box of Kleenex. The staff rearranged the resident's room to ensure the resident could reach frequently used items.<br><br>Review of a Progress Note dated 12/19/24 at 1:31 PM revealed the resident was reaching for an item in the closet, lost balance and fell . The resident's fall alarm was sounding at the time of the fall. The assessment indicated the staff were provided re-education regarding leaving the resident alone in the room when positioned in the wheelchair.<br><br>Review of an Incident Report dated 12/26/24 at 5:40 PM revealed the resident was found on the floor of the resident's room by the bathroom door. The resident identified trying to take self to the bathroom. A new intervention was identified to toilet the resident before and after meals.<br><br>Review of an Incident Report dated 1/4/25 at 7:05 PM revealed the resident was found on the floor next to the resident's bed. The resident identified getting ready for bed, stumbled and fell backwards. An intervention was identified to assist the resident with getting ready for bed after the evening meal.<br><br>Review of an Incident Report dated 1/5/25 at 5:05 PM revealed the staff heard the resident's fall alarm sounding and found the resident on the floor of the bathroom. The resident was incontinent of urine. A new intervention was listed to take the resident to the bathroom every 2 hours when awake.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observations of Resident 19 revealed the following:<br><br>-3/20/25 from 7:43 AM to 9:03 AM the resident was seated in the dining room in a regular chair. No fall alarm was in place to the resident's chair.<br><br>-3/20/25 from 10:11 AM to 11:24 AM the resident was alone in the resident's room, and unsupervised. The video camera was faced away from the resident and did not allow staff to visualize the resident from the Nurse's Station.<br><br>During an interview on 3/24/25 at 11:55 AM the DON confirmed the following regarding Resident 19:<br><br>-the resident had a video camera in the resident's room which was attached to a monitor at the Nurse's Station. Staff were to point the camera at the resident when in the recliner or in bed so the resident could be monitored more closely.<br><br>-fall alarms were to always be on the resident.<br><br>-12/19/24 the staff were re-educated regarding leaving the resident alone and unsupervised in the resident's room. The DON verified there was no evidence as to when the staff were re-educated, and which staff received the education. In addition, no other interventions were developed.<br><br>51391<br><br>D. Review of Resident 15's MDS dated [DATE] revealed the resident had a diagnosis of Non-Traumatic Brain Dysfunction, Alzheimer's Disease and Paranoid Personality Disorder. The following was assessed regarding the resident:<br><br>-cognitive skills for daily decision making was severely impaired.<br><br>- inattention and disorganized thinking continuously.<br><br>- dependent on staff for eating, oral hygiene, toileting hygiene, bathing, dressing and personal hygiene.<br><br>- dependent on staff for repositioning in bed and transferring from bed to chair and tub. - dependent on staff for wheelchair mobility.<br><br>- always incontinent of bowel and bladder.<br><br>- 2 or more falls, 1 with injury and 1 without injury since previous assessment.<br><br>Review of Resident 15's Care Plan dated 10/8/24 revealed the resident was at risk for falls related to poor balance, confusion and the need for assistance with transfers. Nursing interventions with development dates included the following:<br><br>-10/8/24 Do not leave resident unattended alone in room when in the wheelchair. Assist to the recliner or to bed before leaving the room. -10/8/24 Make sure that the bed is in the normal low position at all times except during cares.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -10/8/24 Resident does not remember to pull the call light to ask for assistance when the resident wants to get up. Each time a staff member walks by the room, take the time to get eyes on the resident to ensure safety<br><br>-10/8/24 Transfer with 2 assist and mechanical lift. Make sure the sling fits properly prior to lifting.<br><br>-2/6/25 Ensure residents bed in a locked position before leaving the room<br><br>-3/13/25 Hourly checks done on resident at all times.<br><br>Review of Nursing Progress Note dated 3/13/25 at 6:00 PM revealed the resident was laying on the floor on their stomach beside the bed, had reddened area to left check with no other injuries noted. A new intervention was identified for hourly checks at all times.<br><br>An observation on 3/18/25 at 9:49 AM revealed the resident was sitting in a wheelchair in room alone, rocking back and forth, eyes were open, and resident was moaning.<br><br>An observation on 3/20/25 at 7:15 AM revealed the resident was sitting in a wheelchair in room alone with eyes shut.<br><br>An observation on 3/20/25 at 8:00 AM revealed the resident was sitting in a wheelchair in room alone, eyes were shut, and resident was moaning.<br><br>An interview on 3/20/25 at 10:40 AM with NA-G and MA-H confirmed that the resident was at risk for falls, was to be on hourly checks at all times, staff confirm that hourly checks were not being completed. Staff were unaware of intervention for the resident to be supervised when alone in the wheelchair in the resident's room.<br><br>An interview on 3/20/25 at 2:55 PM with the interim DON confirmed that the resident was at risk for falls. The fall prevention care planned intervention of hourly checks at all times and do not leave resident unattended alone in room when in wheelchair were not being implemented.<br><br>An observation on 3/24/25 at 2:20 PM revealed the resident was lying in bed, awake, trying to sit up, bed was in highest position, no staff were in the room.<br><br>An interview on 3/24/25 at 2:30 PM with NA-K confirmed that the bed was in the highest position when resident was in the bed and resident was alone in the room. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>29638<br><br>LICENSURE REFERENCE NUMBER 175 NAC 12-006.09D3<br><br>Based on observation, record review and interview; the facility staff failed to provide care and management of Resident 6's urinary catheter (tube placed into the bladder to drain urine) to prevent the potential for infections and/or complications. The sample size was 1 and the facility census was 33.<br><br>Findings are:<br><br>A. Review of the facility policy Catheter Cares dated 9/2024 revealed it was the policy of this facility to ensure residents with indwelling catheters received appropriate catheter care and maintained their dignity and privacy when indwelling catheters were in use. The following was indicated:<br><br>-catheter care was be performed every shift and as needed by nursing personnel.<br><br>-privacy bags were to be available and catheter drainage bags were to be always covered while in use.<br><br>-privacy bags were to be switched out when soiled, and with a catheter change was needed.<br><br>-empty drainage bags when the bag was half-full or every 3 to 6 hours.<br><br>-ensure the catheter drainage bag was located below the level of the bladder to discourage backflow of urine.<br><br>The following guidelines were identified for completion of catheter cares:<br><br>-perform hand hygiene and place on gloves.<br><br>-gently grasp penis and draw foreskin back if applicable.<br><br>-using circular motion, cleanse the meatus.<br><br>-starting at the meatus, move down and cleanse the shaft of the penis.<br><br>-with a clean cloth, start at the urinary meatus and move outward, wipe the catheter making sure to hold the catheter in place so as not to pull on the catheter.<br><br>B. Minimum Data Set<br><br>Date: 3/6/25<br><br>Type: Quarterly<br><br>(continued on next page) |

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| | 285124 | A. Building<br>B. Wing | 03/25/2025 |

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| Arbor Care Centers-Neligh LLC | 1100 T Street<br>Neligh, NE 68756 |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | BIMS: 15 out of 15<br><br>Resident mood interview conducted and the resident identified the following:<br><br>-feeling down, depressed or hopeless 12-14 days<br><br>-trouble falling asleep or staying asleep or sleeping too much 7-11 days.<br><br>-feeling tired or having little energy 12-14 days<br><br>-moving or speaking slowly 2-6 days.<br><br>Behaviors: None<br><br>Functional limitation of ROM: no impairment<br><br>Self-Care Status:<br><br>Set-up or clean up assistance with eating/drinking, and oral hygiene.<br><br>Dependent with toileting hygiene, toileting bathing, dressing, and personal hygiene.<br><br>Substantial/maximal assistance with bed mobility and transfers.<br><br>Bowel and bladder:<br><br>indwelling catheter and ostomy.<br><br>Active diagnoses: diabetes, HTN, PVD, hyperlipidemia,, depression, pressure ulcer stage 3, obstructive sleep apnea, and osteoarthritis.<br><br>Pain: denied the presence of pain.<br><br>Prognosis does the resident have a condition or a chronic disease that may result in a life expectancy of less than 6 months. No<br><br>Falls: None<br><br>Weight: 252 pounds, no weight loss//gain.<br><br>Unhealed pressure/venous ulcers: one stage 3 pressure ulcer which was present on admission and a diabetic foot ulcer. Resident has a PRD for chair and bed, nutrition/hydration interventions to manage skin problems, pressure ulcer care, application of nonsurgical dressings, applications of ointments/medications and application of dressings.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Observation of wound care for Resident 6 on 3/20/25 from 10:12 AM to 10:45 AM revealed Licensed Practical Nurse (LPN)-D washed hands and placed on a disposable gown and gloves. LPN-D prepared items to complete the dressing change and placed on a bedside table. LPN-D used the bed controls to lower the bed so that staff could more easily access the resident's wounds. However, once the bed was lowered the urinary catheter drainage bag which was hanging from the bedframe was now positioned directly on the floor underneath of the resident's bed. The catheter drainage bag remained on the floor throughout the completion of wound care.<br><br>During an interview with LPN-D on 3/20/25 at 11:30 AM, the LPN confirmed the resident's catheter drainage bag should not have been positioned on the floor during the wound care.<br><br>During an observation of catheter cares and a transfer on 3/20/25 at 11:40 AM the following was observed:<br><br>-Nurse Aide (NA)-H and NA-G entered the resident's room, washed hands, and placed on gowns and gloves. The resident remained in bed and lying on back. NA-H removed the bed linens and adjusted the resident's clothing to expose the catheter insertion site. The resident was observed to have feces to bilateral groin and lower abdomen.<br><br>-NA-G used pre-moistened cleansing cloths to remove feces. NA-G removed soiled gloves but failed to complete hand hygiene before placing on clean gloves.<br><br>-NA-G completed catheter cares and removed soiled gloves.<br><br>-without performing hand hygiene, NA-G placed on clean gloves and removed the catheter drainage bag from the bed frame and placed directly on the resident's bed linens. The drainage bag contained approximated 700 cubic centimeters (cc) of yellow urine.<br><br>-the catheter drainage bag remained on the resident's bed while the staff removed the PRAFO devices to bilateral feet and changed the resident's clothing.<br><br>-NA-G removed the catheter drainage bag from the bed and placed the bag on the resident's lap. The resident was assisted to sit on the side of the bed.<br><br>-the catheter drainage bag was then removed from the resident's lap and NA-G held the bag against NA-G's uniform as staff placed the resident on the mechanical lift and transferred the resident into the wheelchair.<br><br>-the resident was positioned into the wheelchair and the catheter drainage bag was placed into a privacy bag underneath of the wheelchair.<br><br>During an interview with NA-G on 3/20/25 at 12:00 PM the following was confirmed:<br><br>-the resident's urinary catheter drainage bag was to remain below the level of the resident's bladder with any cares.<br><br>-the catheter drainage bag should not have been placed directly on the bed linens or on the resident's lap.<br><br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -after cleansing the feces from the resident's groin areas and lower abdomen, and after completion of catheter cares, staff should have removed soiled gloves and performed hand hygiene before placing on clean gloves and continuing cares. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>51391<br><br>Licensure Reference Number 175 NAC 12-006.12(A)(vi)<br><br>Based on record review and interviews; the facility failed to follow the consultant pharmacist's recommendations to address irregularities in the medication regimen for Resident 16. The sample size was 6 and the facility census was 33.<br><br>Findings are:<br><br>A. Review of the facility policy Medication Regimen Review (MRR) dated September 2024 revealed the following:<br><br>-The MRR was a thorough process of review and assessment conducted by a Consultant Pharmacist of the medications ordered for each resident, with a goal of promoting positive outcomes and minimizing adverse consequences associated with medications.<br><br>-The MRR occurred monthly for each resident and recommendations were reported to the Administrator, Director of Nursing, attending physicians, and the Medical Director as it applied.<br><br>-The Consultant Pharmacist utilized federally mandated standards of care, in addition to other applicable standards.<br><br>-The Consultant Pharmacist provided reporting each month including documented concerns, irregularities, clinically significant risks, adverse consequences that resulted from of could be associated with medications.<br><br>-The reports included nursing issues as well as communication to attending physicians.<br><br>-Letters were provided to attending physicians regarding any significant potential or actual medication concerns.<br><br>-Facility staff notified the attending physicians and obtained responses within a timely manner.<br><br>B. Review of Resident 16's Minimum Data Set (MDS-federally mandated comprehensive assessment used in the development of the resident care plan) dated 1/9/25 revealed the resident received an antidepressant medication.<br><br>Review of Resident 16's Order Summary Report sheet dated 1-31-2025 revealed that resident had an order for Mirtazapine (Remeron) (antidepressant) 7.5 milligrams (mg) by mouth at bedtime for appetite also related to insomnia.<br><br>Review of Consultant Pharmacist's MRR for Resident 16 revealed the following:<br><br>8/14/2024-Need a consent for the following medication: Remeron.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 12/09/2024-Need a consent for the following medication: Remeron.<br><br>01/15/2025-Need a consent for the following medication: Remeron.<br><br>02/10/2025-Need a consent for the following medication: Remeron.<br><br>Informed consent for Remeron was signed by responsible party on 3/18/25, 7 months after the pharmacist made their initial recommendation.<br><br>An interview on 03/20/25 at 1:55 PM with the Director of Nursing, Registered Nurse (RN-L) and Social Services Director confirmed that the facility had not addressed the Consultant Pharmacist MRR request in a timely manner or in accordance with facility policy. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638<br><br>Licensure Reference Number 175 NAC 12-006.17<br><br>Based on observation, record review, and interview; the facility failed to prevent the potential for cross contamination as the staff failed to utilize the required Personal Protective Equipment (PPE) when performing direct cares for Resident 6 who was on Enhanced Barrier Precautions and to change gloves and perform hand hygiene at appropriate intervals when providing wound care for Residents 5 and 6. The total sample size was 19 and the census was 33.<br><br>Findings are:<br><br>A. Review of the facility policy Infection Prevention and Control Program with a revision date of 5/16/23 revealed the facility had established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections.<br><br>B. Review of the facility policy Hand Hygiene dated 9/2024 revealed all staff were to perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene was the general term for cleaning your hands by handwashing with soap and water or the use of antiseptic hand rub also known as alcohol-based hand rub. (ABHR). The use of gloves would not replace hand hygiene. If gloves were required, staff were to perform hand hygiene prior to donning and immediately after removing gloves.<br><br>C. Review of the Clean Dressing Change Policy dated 9/24 revealed it was the policy of this facility to provide wound care in a manner to decrease the potential for infection and/or cross contamination. The following guidelines were identified:<br><br>-each wound will be treated individually.<br><br>-when multiple wounds were being dressed, the dressings would be changed in order of least contaminated to most contaminated. Dressings of infected wounds should be changed last.<br><br>-set-up a clean filed on the overbed table with the needed supplies for wound cleansing and dressing application.<br><br>-establish an area for soiled products to be placed.<br><br>-perform hand hygiene and place on clean gloves.<br><br>-remove the existing dressing.<br><br>-remove gloves, discard, complete hand hygiene and put on clean gloves.<br><br>-cleanse the wound and pat dry with gauze.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -measure wound using a disposable measuring guide.<br><br>-remove soiled gloves, discard, perform hand hygiene and place on clean gloves.<br><br>-dress wound as ordered and secure dressing.<br><br>-discard disposable items including gloves and wash hands.<br><br>D. Review of the Enhanced Barrier Precautions (EBP) Policy with a revision date of 5/24 revealed it was the policy of this facility to implement EBP for the prevention of the transmission of multidrug resistant organisms. EBP refers an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employed a targeted gown, and gloves use during high contact resident care activities. EBP were to be used for residents with any of the following; chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, chronic venous stasis ulcers and/or indwelling medical devices such as urinary catheters, central lines, feeding tubes, and tracheostomy/ventilator tubes. The use of PPE for residents on EBP was necessary when performing high-contact care activities such as the following:<br><br>-dressing.<br><br>-bathing/showering.<br><br>-transferring.<br><br>-providing hygiene.<br><br>-changing linens.<br><br>-changing briefs or assisting with toileting.<br><br>-device care or use.<br><br>-wound care.<br><br>E. Review of Resident 6's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 3/6/25 revealed the resident was admitted [DATE] with diagnoses of diabetes, peripheral vascular disease, depression and a stage 3 (staging system is a method of summarizing characteristics of pressure ulcers including the extent of tissue damage. A stage 3 ulcer is a full thickness tissue loss. The subcutaneous fat may be visible, but bone, tendon or muscle is not exposed. Slough (dead tissue) may be present but does not obscure the depth of tissue loss) pressure ulcer. The stage 3 pressure ulcer and a diabetic foot ulcer were both present with the resident's admission.<br><br>Observation of wound care for Resident 6's right foot pressure ulcer and left foot diabetic ulcer on 3/20/25 at 10:12 AM revealed the following:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -Licensed Practical Nurse (LPN)-D entered the resident's room, washed hands, and placed on a disposable gown and gloves. LPN-D positioned a barrier on a bedside table and placed items needed for the dressing changes on the barrier.<br><br>-LPN-D removed the Coban and the gauze wraps which had been used to keep the dressing in place to the sole of the resident's right foot. LPN-D sprayed saline wound wash onto the dressing, which had a small amount of brown shadow drainage until the dressing was no longer adhered to the wound bed and removed the dressing.<br><br>-after removal of the soiled dressing, LPN-D did not remove gloves but proceeded to cleanse the wound bed and then to pat dry. The resident's wound was covered with black eschar (dead tissue) and the perimeter of the wound had a deep pink color with dry and flakey skin.<br><br>-while still wearing the same gloves, LPN-D applied a clean dressing to the wound and re-wrapped with gauze and Coban.<br><br>-after completing the dressing change to the resident's right foot, LPN- removed soiled gloves but failed to complete hand hygiene before putting on a clean pair of gloves.<br><br>-LPN-D removed the dressing to the wound site on the side of the resident's left foot.<br><br>-without removing soiled gloves, LPN-D cleansed the wound with saline wound wash and completed the dressing change.<br><br>-after completion of the dressing change, and without removing soiled gloves, LPN-D placed a heel protector on the resident's left foot, positioned the resident for comfort and adjusted the resident's bed linens.<br><br>-LPN-D removed disposable gown and gloves and exited the resident's room still without performing hand hygiene.<br><br>During an interview with LPN-D on 3/20/25 at 11:30 AM the following was confirmed:<br><br>-the resident was currently on EBP related to a diabetic ulcer and pressure ulcers.<br><br>-when completing wound care, should have removed gloves, and performed hand hygiene after removing the soiled dressings and then placed on clean gloves.<br><br>-should have performed hand hygiene each time clean gloves were donned and when removing soiled gloves.<br><br>During an interview with NA-G on 3/20/25 at 12:00 PM the following was confirmed:<br><br>-the resident's urinary catheter drainage bag was to remain below the level of the resident's bladder with any cares.<br><br>-the catheter drainage bag should not have been placed directly on the bed linens or on the resident's lap.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | -after cleansing the feces from the resident's groin areas and lower abdomen, and after completion of catheter cares, staff should have removed soiled gloves and performed hand hygiene before placing on clean gloves and continuing cares.<br><br>F. Review of Resident 5's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of pneumonia, heart failure, non-Alzheimer's dementia, Parkinson's disease, bipolar disorder, and morbid obesity. The resident was identified as having one unstageable (the stage is not clear; the base of the wound is covered by a layer of dead tissue and are unable to see the base of the wound to determine a stage) pressure ulcer which was not present on admission.<br><br>During an observation of toileting cares for Resident 5 on 3/20/25 at 9:25 AM the following was observed:<br><br>-the resident's bathroom call light was activated. NA-G and NA-H entered the resident's room, performed hand hygiene, and placed on clean gloves. Staff did not place on gowns and no gowns were visible in the resident's room.<br><br>-the resident was in the bathroom and was attached to the mechanical lift. Staff assisted the resident per the mechanical lift into a standing position and NA-G performed hygiene cares with pre-moistened cleansing cloths.<br><br>-the resident was transferred out of the bathroom with the lift and was transferred into a wheelchair.<br><br>-staff removed gloves and washed hands before leaving the resident's room.<br><br>During an interview on 3/20/25 at 11:45 AM, NA-G confirmed the resident had a pressure ulcer which was not resolved and continued to receive treatment. However, the wound vac treatment (uses a device to apply negative pressure to a wound to promote healing by removing fluid and debris and encouraging blood flow) had been discontinued so NA-G thought the resident was no longer on EBP.<br><br>The following was observed during wound care for Resident 5 on 3/20/25 at 1:40 PM:<br><br>-without performing hand hygiene, LPN-D placed on a disposable gown and gloves.<br><br>-the dressing was removed from the right buttock area which had a small area of brownish drainage.<br><br>-LPN-D removed gloves and without performing hand hygiene placed on a new pair of gloves.<br><br>-the wound was cleansed with wound wash and was patted dry.<br><br>-a barrier cream was applied to the area surrounding the wound bed with LPN-D's gloved hand.<br><br>-LPN-D removed gloves but failed to complete hygiene before putting on a clean pair of gloves and applying a dressing to the wound.<br><br>-with completion of wound care, LPN-D removed gloves and gown but failed to perform hand hygiene before exiting the resident's room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview was conducted with LPN-D on 3/20/25 at 2:00 PM and the following was confirmed:<br><br>-the resident's pressure ulcer had improved but was not healed and the resident was still on EBP.<br><br>-should have performed hand hygiene each time clean gloves were donned and when removing soiled gloves. |