

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285134	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/13/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Elkhorn		STREET ADDRESS, CITY, STATE, ZIP CODE  20275 Hopper Street Elkhorn, NE 68022	

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 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49164</p> <p>Licensure Reference Number 175 NAC 12.006.02(H)</p> <p>Based on observation, interview and record review the facility failed to report a fall resulting in serious bodily injury to the state agency for 1 (Resident 2) of 1 residents sampled. The facility census was 86.</p> <p>Findings are:</p> <p>Record Review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 06-21-2024 revealed Resident 2 had diagnosis of Dementia, Chronic Obstructive Pulmonary Disease (COPD), anxiety and depression. The MDS also indicated Resident 2 needed staff to set up and supervise bathing and was independent with bed mobility, dressing, hygiene, and ambulation.</p> <p>Record Review of Resident 2's Progress Notes (PN) dated 08-08-2024 revealed Resident 2's roommate yelled for help and staff found Resident 2 on the bathroom floor, curled up on the right side. The PN also indicated the resident was crying and had bleeding from the right cheek. The facility staff called 911 and Resident 2 was transferred to the hospital.</p> <p>Record review of Resident 2's PN dated 8-08-2024 with a time identified as 9:57 AM revealed Resident 2 returned to the facility from the hospital. According to the PN dated 8-08-2024 with a time of 9:57 AM revealed Resident 2 had received 3 stitches to the right upper cheek.</p> <p>An interview conducted on 08-08-2024 with Registered Nurse (RN) J revealed Resident 2 had a fall during the night and was sent to the hospital. RN J also revealed Resident 2 had sutures placed to the laceration on the right cheek at the hospital.</p> <p>An observation on 08-08-2024 at 11:05 AM revealed Resident 2 had returned to the facility with a band aid on the right cheek.</p> <p>An interview conducted with RN J on 08-08-2024 at 11:55 AM confirmed Resident 2 had fallen on 08-08-2024 resulting in a laceration requiring sutures.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record Review of the facility policy Abuse-Reporting and Response-No Crime Suspected dated 06-17-2024 revealed:</p> <p>-The facility will report alleged violations related to mistreatment, exploitation, neglect, or abuse including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities (including the State Survey Agency and Adult Protective Services, APS) within prescribed timeframe's.</p> <p>-Initial Report-</p> <p>-For alleged abuse or if there is serious bodily injury, the facility must report the allegation immediately, but no later than 2 hours after the allegation is made.</p> <p>An interview conducted with the Director of Nursing (DON) on 08-12-2024 at 1:35 PM confirmed Resident 2 fell on [DATE] and was sent to the hospital for a laceration to the right cheek that required sutures. The DON also indicated that the fall with serious bodily injury had not been reported to any state agency.</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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45641</p> <p>Licensure Reference Number 175 NAC 12-006.18(B)</p> <p>Licensure Reference Number 175 NAC 12-006.18(C)</p> <p>Based on observations, record review and interview; the facility staff failed to ensure Resident 26, 38, and 42's respiratory equipment and supplies was cleaned and sanitized to prevent cross contamination, failed to implement enhanced barrier precautions during ADL care for Resident 14, and during catheter care for Resident 37, and failed to provide enhanced barrier signage for 1, Resident 68. The total sample size of the survey was 18. The facility staff identified a census of 86.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of the facility's Bilevel Positive Airway Pressure (BiPAP)/Continuous Positive Airway Pressure (CPAP)(machines used to treat apnea) Administration Policy with a reviewed date of 09/26/2023 masks should be cleaned with soap and water as needed.</p> <p>A record review of the facility's Oxygen Administration policy with a revised date of 02/27/2024 revealed the exterior of the oxygen concentrators (a machine that purifies oxygen) should be cleaned weekly.</p> <p>A record review of the facility's Nebulizer (Neb) Treatment (device used to administer liquid medications to the lungs), small volume policy with a last reviewed date of 05/29/2024 revealed the facility should rinse the nebulizer with sterile water and allow it to air dry or discard after the treatment.</p> <p>An observation on 08/08/2023 at 3:21 PM revealed Resident 26's neb kit was in a plastic bag, but the mask had facial oils on it and there was a residual (leftover) amount of medication in the cup. The resident Positive Airway Pressure (PAP) mask was draped over the over-bed table with facial oils on it. The PAP filter was coated with a gray fuzzy substance, and all the machines had a gray fuzzy substance on them.</p> <p>An observation on 08/12/2023 at 10:04 AM revealed Resident 26's neb kit was on the floor and the mask had facial oils on it and there was a residual amount of medication in the cup. The resident's PAP mask was draped over the over-bed table with facial oils and a white coating on it. The PAP filter was coated with a gray fuzzy substance, and all the machines had a gray fuzzy substance on them.</p> <p>An observation on 08/12/2023 at 2:20 PM with Licensed Practical Nurse (LPN)-N revealed Resident 26's PAP mask was draped over the over-bed table with facial oils and a white coating on it. The PAP filter was coated with a gray fuzzy substance, and all the machines had a gray fuzzy substance on them.</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>In an interview on 08/12/2024 at 10:14 AM, the Director of Nursing (DON) confirmed the DON seen the nebulizer kit on the floor and threw it away. It should not have been on the floor.</p> <p>In an interview on 08/12/2024 at 2:20 PM, LPN-N confirmed the resident's PAP mask should be clean, the PAP filter should be clean, and the surfaces of the units should be clean, and they were not.</p> <p>B.</p> <p>An observation on 08/07/2023 at 2:06 PM revealed Resident 42's nebulizer kit was in a plastic bag, but the mask had facial oils on it and there was a residual amount of medication in the cup. The resident ventilator mask was in a plastic bag with facial oils on it. The resident's ventilator had a gray fuzzy substance and debris on it. The air intake on the concentrator was coated with a gray fuzzy substance, and all the machines had a gray fuzzy substance on them.</p> <p>An observation on 08/08/2023 at 3:22 PM revealed Resident 42's nebulizer kit was in a plastic bag, but the mask had facial oils on it and there was a residual amount of medication in the cup. The resident ventilator mask was in a plastic bag with facial oils on it. The resident's ventilator had a gray fuzzy substance and debris on it. The air intake on the concentrator was coated with a gray fuzzy substance, and all the machines had a gray fuzzy substance on them.</p> <p>An observation on 08/12/2023 at 2:55 PM with LPN-N revealed Resident 42's nebulizer kit was in a plastic bag, but the mask had facial oils on it and there was a residual amount of medication in the cup. The resident ventilator mask was in a plastic bag with facial oils and debris on it. The resident's ventilator had a gray fuzzy substance and debris on it. The air intake on the concentrator was coated with a gray fuzzy substance, and all the machines had a gray fuzzy substance on them.</p> <p>In an interview on 08/12/2024 at 2:55 PM, LPN-N confirmed the resident's PAP mask and nebulizer kit should be clean, the concentrators air intake should be clean, and the surfaces of the units should be clean, and they were not.</p> <p>A record review of the facility's BiPAP/CPAP Administration Policy with a reviewed date of 09/26/2023 masks should be cleaned with soap and water as needed.</p> <p>A record review of the facility's Oxygen Administration policy with a revised date of 02/27/2024 revealed the exterior of the oxygen concentrators should be cleaned weekly.</p> <p>A record review of the facility's Nebulizer Treatment, small volume policy with a last reviewed date of 05/29/2024 revealed the facility should rinse the nebulizer with sterile water and allow it to air dry or discard after the treatment.</p> <p>C.</p> <p>An observation on 08/12/2024 at 7:42 AM revealed Resident 38's PAP mask had facial oils and debris on it, the PAP headgear had a large brown dried mark on it, the nebulizer machine had brown stains and hair on it, the PAP filter had a thick gray fuzzy substance on it. The PAP and concentrator had a gray fuzzy coating on them.</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>An observation on 08/12/2024 at 2:30 PM with LPN-P revealed Resident 38's PAP mask had facial oils and debris on it, the PAP headgear had a large brown dried mark on it, the nebulizer machine had brown stains and hair on it, the PAP filter had a thick gray fuzzy substance on it. The PAP and concentrator had a gray fuzzy coating on them.</p> <p>In an interview on 08/12/2024 at 7:42 AM Resident 38 confirmed the staff did not clean the resident's respiratory equipment and supplies.</p> <p>In an interview on 08/12/2024 at 2:30 PM, LPN-P confirmed all the equipment and supplies were not clean and should have been.</p> <p>A record review of the facility's BiPAP/CPAP Administration Policy with a reviewed date of 09/26/2023 masks should be cleaned with soap and water as needed.</p> <p>A record review of the facility's Oxygen Administration policy with a revised date of 02/27/2024 revealed the exterior of the oxygen concentrators should be cleaned weekly.</p> <p>49164</p> <p>D.</p> <p>Record Review of Resident 37's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 06-28-2024 revealed an admitted [DATE] following hospitalization for surgery of a diaphragmatic Hernia with Obstruction (is a protrusion of abdominal contents into the thoracic cavity due to a defect within the diaphragm), other diagnosis included Gastro Esophageal Reflux Disease (GERD, is a long-term condition that occurs when stomach acid flows back up into the esophagus), Benign Prostatic Hypertrophy (BPH, a non-cancerous condition that causes the prostate gland to enlarge in men), Chronic Obstructive Pulmonary Disease (COPD), Barrett's Esophagus (is a condition in which the flat pink lining of the swallowing tube that connects the mouth to the stomach (esophagus) becomes damaged by acid reflux, which causes the lining to thicken and become red) with dysphagia (difficulty swallowing) and an indwelling urinary catheter(is a thin, flexible tube that is inserted into the bladder through the urethra or stomach wall to collect and drain urine). The MDS also indicated Resident 37 had a Brief Interview of Mental Status (BIMS, an assessment that aids in detecting cognitive impairment. A score of 0-7 equals severe impairment, 8-12 indicates moderate impairment and 13-15 indicates cognitively intact) score of 15 and required set up assistance from staff for oral and personal hygiene, partial assistance for dressing, substantial assistance with bed mobility and was dependent on staff for bathing and transfers. The MDS also revealed Resident 14 weighed 120 pounds and was 64 inches tall.</p> <p>An observation on 08-12-2024 at 4:10 AM of Medication Aid (MA) D entering Resident 37's room revealed a sign on the outside of the door stating Enhanced Barrier Precautions (EBP). The sign indicated that staff should wear a gown and gloves during the following High Contact Resident Care Activities -device care or use of a urinary catheter. MA D entered the room without a gown, went to the bathroom performed hand hygiene and returned from the bathroom wearing gloves, carrying a graduate. MA D set the graduate on the floor, opened the spigot on the catheter drainage bag and drained the bag into the graduate. After the emptying the drainage bag, MA D placed the spigot back into the holder on the bag and took the graduate into the bathroom and discarded the urine in the toilet. MA performed removed gloves performed hand hygiene and left the room.</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>An interview conducted with MA D on 08-12-2024 at 4:29 AM confirmed that a gown was not worn while draining Resident 37's catheter bag because Resident 37 is no longer on precautions.</p> <p>An interview with Licensed Practical Nurse (LPN) I on 08-12-2024 at 5:05 AM revealed Resident 37 was on EBP for a urinary catheter.</p> <p>Record Review of the facility policy Enhanced Barrier Precautions dated 03-21-2024 revealed a policy statement- The facility should use EBP as an additional Multi Drug Resistant Organism (MDRO) mitigation strategy for residents that meet the following criteria, during high contact resident care activities:</p> <p>EBP are indicated for residents with any of the following:</p> <ul style="list-style-type: none"> <li>-Infection or colonization with a Centers of Disease Control (CDC)-targeted MDRO when contact precautions do not otherwise apply; or</li> <li>-Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.</li> <li>-wounds include chronic wounds such as pressure ulcers and diabetic foot wounds.</li> <li>-indwelling medical device examples include central lines, urinary catheters, and feeding tubes.</li> </ul> <p>An interview with the facility Wound Nurse (WN) on 08-12-2024 at 5:10 AM confirmed that a gown should have been worn by the staff when emptying a urinary catheter drainage bag.</p> <p>E.</p> <p>Record Review of Resident 14's MDS dated [DATE] revealed an admitted [DATE] and a readmitted [DATE]. Diagnosis that were listed on the MDS were Peripheral Vascular Disease (PVD, is a systemic disorder that involves the narrowing of peripheral blood vessels), Cerebrovascular Disease (is a term for conditions that affect blood flow to your brain) with hemiphegia (weakness) on the left side, dysphagia (difficulty swallowing), and dysarthria (slurred speech), Chronic Obstructive Pulmonary Disease (COPD, prevents airflow to the lungs, causing breathing problems.), and morbid obesity, The MDS also revealed Resident 14 had a BIMS score of 14 and required supervision with oral hygiene and eating, partial assistance with personal hygiene, substantial assistance with showering and upper body dressing and was dependent on staff for bed mobility, transfers, lower body dressing and toileting. The MDS also indicated Resident 14 had obvious or likely cavity or broken natural teeth.</p> <p>An observation on 08-13-2024 at 7:01 AM revealed an EBP sign outside Resident 14's room indicating staff should wear a gown and gloves during high contact resident care activities such as bathing, transferring, dressing, or providing hygiene. This observation after entering the room revealed Nurse Aid (NA) D, NA G and NA F were wearing gloves but not gowns while transferring Resident 14 out of the shower chair and back into bed. NA G was using a mechanical lift to transfer Resident 14 into bed while NA D was guiding the resident while the lift was moved from the shower chair to the bed, and NA F was collecting linens from the bath chair and the bed.</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>An interview with NA D, NA G and NA F on 08-13-2024 at 7:01 AM confirmed when Resident 14 returned to the room after the shower the nurse aids should have donned gowns and gloves before transferring and providing care to Resident 14.</p> <p>Record Review of the facilities Weekly EBP Update dated 08-07-2024 listed Resident 14 on EBP for wounds.</p> <p>Record Review of the facility policy Enhanced Barrier Precautions dated 03-21-2024 revealed a policy statement- The facility should use EBP as an additional Multi Drug Resistant Organism (MDRO) mitigation strategy for residents that meet the following criteria, during high contact resident care activities:</p> <p>EBP are indicated for residents with any of the following:</p> <ul style="list-style-type: none"> <li>-Infection or colonization with a Centers of Disease Control (CDC)-targeted MDRO when contact precautions do not otherwise apply; or</li> <li>-Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.</li> <li>-wounds include chronic wounds such as pressure ulcers and diabetic foot wounds.</li> <li>-indwelling medical device examples include central lines, urinary catheters, and feeding tubes.</li> </ul> <p>An interview on 08-13-2024 at 7:40 AM with Registered Nurse J confirmed that staff are to wear a gown and gloves during high contact resident care activities for residents with wounds or indwelling medical devices.</p> <p>50106</p> <p>F.</p> <p>Record review of Resident 68's Clinical Census revealed an admitted [DATE].</p> <p>Record review of Resident 68's MDS revealed Resident 68 had a BIMS of 12. A BIMS of 12 indicated that the resident had moderate cognitive impairment. Resident 68 was independent with bed mobility, transfers, eating, and toileting.</p> <p>Record review of Resident 68's Wound Assessments dated 7/12/24 revealed the resident had venous stasis ulcer wounds with serous drainage (a clean, thin, and watery fluid that leaks from a wound that has tissue damage). The Wound Assessment documented the venous stasis ulcers were found on 7/9/24.</p> <p>Observation of Resident 68's door on 8/7/24 leading to the resident's room revealed no signage for Enhanced Barrier Precautions (EBP).</p> <p>Observation of Resident 68's door on 8/8/24 leading to the resident's room revealed no signage for EBP.</p> <p>(continued on next page)</p>		

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