

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Wayne Countryview Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 811 East 14th Street Wayne, NE 68787	

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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638</p> <p>LICENSURE REFERENCE NUMBER 175 NAC 12-006.10(A)(i)</p> <p>Based on observations, record review and interview; the facility staff failed to evaluate Resident 85 for the ability to self-administer medications and to ensure security of medications. The total sample size was 26 and the facility census 34.</p> <p>Findings are:</p> <p>A. Review of the facility policy Self-Administration of Medications with a revision date of 5/23 revealed it was the policy of the facility to respect the wished of alert, competent residents to self-administer prescribed medications as allowable under state regulations. The following procedures were to be followed:</p> <ul style="list-style-type: none"> -upon admission, alert residents were to be informed of their right to self-administer medications. -if a resident would desire to participate in self-administration, the interdisciplinary team would then assess the resident and then periodically re-evaluate as needed. -if a resident is a candidate for self-administration of medications, this will be indicated in the resident's medical record. -the resident would be instructed regarding proper administration of medications by the nurse, and this will then be care planned. -nursing will be responsible for recording self-administration doses in the resident's medical Medication Administration Record (MAR). -storage and location of drug administration will comply with state and federal requirements for medication storage. <p>B. Review of Resident 85's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 10/11/24 revealed the resident was admitted on [DATE] with diagnoses of cancer, anemia, coronary artery disease, heart failure, high blood pressure, end stage renal disease, seizure disorder and anxiety. The following was assessed regarding the resident:</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-cognition was moderately impaired.</p> <p>-no behaviors.</p> <p>-resident was on oxygen and received dialysis.</p> <p>During observations on 10/9/24 at 9:32 AM, on 10/10/24 at 8:32 AM, and on 10/15/24 at 7:36 AM, Resident 85 had a container of Tums antacid tablets, without a medication label on a shelf in the resident's bathroom.</p> <p>Review of Resident 85's electronic medical record revealed no evidence the resident had a physician order for the Tums antacid tablets located in the resident's bathroom. In addition, there was no evidence the resident had been assessed to determine the resident was competent to self-administer medications.</p> <p>During an interview on 10/16/24 at 9:38 AM, Licensed Practical Nurse (LPN)-O confirmed the resident did not have an order for the Tums antacid tablets stored in the resident's bathroom and the resident had not been evaluated to determine ability to self-administer medications. The resident's cognition was moderately impaired, and LPN-O did not feel the resident was eligible to self-administer medications.</p>

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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>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360</p> <p>LICENSURE REFERENCE NUMBER 175 NAC 12-006.19(A)</p> <p>Based on observation and interview; the facility failed to ensure a clean, comfortable, and homelike environment. The facility census was 34.</p> <p>Findings are:</p> <p>During the course of the survey from 10/9/24 through 10/16/24 the following was observed:</p> <ul style="list-style-type: none"> -on 10/9/24 at 12:30 PM multiple stained and sagging ceiling tiles were observed in the hallway entrance adjacent to the south side of the dining room. In addition, the same hallway had a 10-to-12-foot pitted and chipped line in the dry wall on the east wall. -on 10/10/24 at 9:10 AM the dry-wall adjacent to Resident 1's bed in room [ROOM NUMBER] was gouged open approximately 1 inch by 24 inches. -on 10/10/24 at 9:20 AM multiple rooms in the center hallway (hall 400) were noted to be soiled and have carpet stains in rooms [ROOM NUMBER]. The threshold to room [ROOM NUMBER] was taped down with a red colored industrial tape. <p>During an environmental tour on 10/10/24 the following was noted:</p> <ul style="list-style-type: none"> -Door frames throughout the facility leading into residents' rooms had chipped and missing paint. -The floor around the door frames to resident rooms on the 300 hallway were caked with a layer of dirt and debris. -The alcove outside of the laundry area where 2 recliners and a vending machine were stored, had a heavy layer of dust and the tile was visibly dirty. -The threshold of the double door entry to the 300 hallway was taped with black, orange, and red industrial tape which was heavily scuffed and peeling at the edges. -Multiple areas of paint on the 400 hallway walls were chipped. -Paint on the drywall adjacent to Resident 12's bed in room [ROOM NUMBER] was chipping away in multiple places. <p>(continued on next page)</p>		

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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>-The floor beneath the ice machine located in the dining room was noted to have the floor drain cap unsecured and sitting off to the side of the drain with a clear hose lying on top of the draining with a thick slimy substance and a slow drip of clear liquid dripping from the tubing into the drain. The floor around the drain had a layer of white lime build up noted and the painted floor was chipped and heavily soiled. A filter on the side of the ice machine was heavily coated in dust and debris.</p> <p>-on 10/10/24 at 1:47 PM Resident 1 was lying in bed and a fall mat placed on the floor beside the bed had multiple tears and split seams present.</p> <p>-on 10/10/24 at 2:45 PM The linoleum in room [ROOM NUMBER] had an approximate 5 x 8-inch tear that was sticking up directly in front of a recliner.</p> <p>During a tour and interview with the facility Administrator on 10/16/24 at 8:42 AM the Administrator confirmed the identified concerns required repair and/or maintenance. Additional interview revealed the staff communicated maintenance concerns through a computer program and the facility had identified that the previous/former Maintenance Supervisor had been removing work orders without repairing things. The facility has now employed a new Maintenance Supervisor.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>29638</p> <p>LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(H)(i)(1)</p> <p>Based on observations, record review and interview; the facility failed to provide toileting assistance and incontinence management for Resident 13 who required assistance with activities of daily living. The facility census was 34 and the sample size was 2.</p> <p>Findings are:</p> <p>A. Review of the facility policy Incontinent Care dated 5/2007 revealed it was the policy of the facility to provide a dry and odor free perennial care system. The policy indicated the residents were to be checked at least every 2-3 hours for incontinence.</p> <p>B. Review of Resident 13's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 9/10/24 revealed diagnosis of diabetes, anemia, non-Alzheimer's dementia, anxiety, and depression. The same assessment indicated the resident's cognition was severely impaired, the resident was dependent with toileting hygiene, transfers and personal hygiene and indicated the resident was always incontinent of bowel and bladder.</p> <p>Review of Resident 13's current Care Plan with revision date of 12/11/23 indicated the resident was dependent on staff for assistance with activities of daily living. The resident wore a disposable incontinence brief, and the resident was incontinent of bowel and bladder.</p> <p>Observations of Resident 13 on 10/9/24 revealed the resident was seated in a wheelchair and was positioned in the center of the 400 corridor. The resident had a strong odor of feces. Several staff were observed in the corridor and passing by the resident, but no staff offered the resident assistance with toileting and/or incontinence cares.</p> <p>Observations of Resident 13 on 10/10/24 revealed the following:</p> <p>-7:15 AM the resident was awake and dressed for the day. The resident was seated in a wheelchair in the resident's room.</p> <p>-7:46 AM the resident was assisted to the dining room for the breakfast meal. The resident was not offered toileting assistance before going out to the dining room.</p> <p>-8:30 AM the resident was assisted out of the dining room and was positioned in the corridor outside of the resident's room. The resident was not offered an opportunity to use the bathroom or provided assistance with incontinence cares.</p> <p>-8:30 AM to 10:55 AM the resident remained in the corridor outside of the resident's room. The resident was noted to have a strong urine odor.</p> <p>-10:58 AM the resident was assisted to the dining room and positioned at a dining table. The resident continued to have a urine odor.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-11:15 AM Nurse Aide (NA)-K assisted the resident from the dining room and back to the resident's room. NA-K and NA-J provided the resident assistance into the bathroom and prepared to transfer the resident onto the toilet. The resident's slacks, incontinence brief and the pad in the seat of the resident's wheelchair were saturated with urine.</p> <p>During an interview on 10/10/24 at 1:29 PM, NA-J and NA-K indicated the resident was up and had been dressed by the night shift that morning. Staff confirmed on 10/10/24 they had not assisted the resident with toileting until 11:14 AM (a minimum of four hours since the resident was last provided assistance). Staff indicated the resident should have been toileted when gotten up that morning and then again before and after the breakfast meal.</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638</p> <p>Licensure Reference Number 175 NAC 12-006.09</p> <p>Based on observations, interview, and record review; the facility failed to follow Resident 85's physician order regarding a fluid restriction. The sample size was 1 and the facility census was 34.</p> <p>The findings are:</p> <p>A. Review of the facility policy Fluid Restriction with a revised date of 5/2007 revealed it was the policy of the facility to provide fluids as specified by the physician order. The following procedures were identified:</p> <ul style="list-style-type: none"> -nursing was to notify dietary department of the parameters ordered for the resident's fluid restriction to include the minimum and maximum allowance. -the Dietary Manager (DM) was to divide the allotted total fluid amount for dietary among the daily meal pattern and enter the specified amounts in the resident's diet card. -nursing was to document fluid restrictions with the resident's intake and outputs on the Medication Administration Record (MAR). -the resident was to be educated regarding benefits/risks of compliance/noncompliance with fluid parameters. -water pitchers were not to be provided at the resident's bedside. <p>B. Review of Resident 85's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 10/11/24 revealed the resident was admitted on [DATE] with diagnoses of cancer, anemia, coronary artery disease, heart failure, high blood pressure, end stage renal disease, seizure disorder and anxiety. The following was assessed regarding the resident:</p> <ul style="list-style-type: none"> -cognition was moderately impaired. -independent with eating and drinking. -no behaviors. -resident was on oxygen and received dialysis. <p>Review of Resident 85's admission orders dated 10/8/24 revealed the resident had an order for a 2000 milliliter (ml) fluid restriction in 24 hours with the following breakdown:</p> <ul style="list-style-type: none"> -day shift nursing allotted 480 ml and 240 ml for the breakfast meal. -evening shift nursing allotted 480 ml with 240 ml for the noon meal. <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>-evening/night nursing shift allotted 320 ml with 240 ml for the evening meal.</p> <p>Review of the resident's medical revealed from 10/8 through 10/10 revealed no documentation to indicate the facility was monitoring the resident's intakes and outputs to ensure compliance with the resident's physician ordered fluid restriction.</p> <p>Observations of the provision of fluids for Resident 85 revealed the following:</p> <p>-10/9/24 at 2:34 PM the resident was seated in a recliner in the resident's room. Next to the recliner was a bedside table which held a full water pitcher containing 600 ml of water despite the resident's fluid restriction.</p> <p>-10/10/24 at 8:32 AM the resident's bedside table contained a full water pitcher with 600 ml of water and 2 Styrofoam cups with approximately 120 ml of water left in each of the cups.</p> <p>An interview with the Director of Nursing (DON) on 10/10/24 at 3:03 PM confirmed the resident currently had a physician order for a 2000 ml fluid restriction. The DON further confirmed the following:</p> <p>-a full water pitcher should not have been provided in the resident's room.</p> <p>-the Charge Nurses were to document the resident's intakes and outputs for each shift on the resident's MAR to ensure the resident's fluid restriction was followed.</p>

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>29638</p> <p>LICENSURE REFERENCE NUMBER 175 NAC 12-006.09</p> <p>Based on record review and interview; the facility failed to monitor a dialysis (a method used to treat kidney disease by clearing metabolic waste products, toxins, and excess fluid from the blood) access site for 1 (Resident 85) of 1 resident. The facility staff identified a census of 34.</p> <p>Findings are:</p> <p>A. Review of the facility policy Renal Dialysis, Care of Resident with a revision date of 6/09 revealed the following guidelines in the care of the resident on renal dialysis.</p> <ul style="list-style-type: none"> -access site to be checked for condition, bruit (whooshing sound heard near the site with a stethoscope) and thrill (a thrill or buzz like vibration caused by blood flowing through the fistula) every shift. -physician to be notified of any complications. -blood pressures and venous punctures not to be performed on the extremity with the access site. -staff to prevent, identify and manage potential complications. <p>B. Review of the resident's admission orders dated 10/8/24 revealed the resident was to receive renal dialysis 3 times a week on Mondays, Wednesdays, and Fridays.</p> <p>Record review of Resident 85's medical record that included Nursing Progress notes, Treatment Administration Record (TAR) and Medication Administration Form (MAR) revealed there was no evidence the facility nursing staff were monitoring the dialysis access site.</p> <p>During an interview on 10/15/24 at 10:25 AM, Licensed Practical Nurse (LPN)-O confirmed the staff were to assess the dialysis access site for any signs of complications after the resident's dialysis treatment and were to assess the site for bruit and thrill each shift. LPN-O confirmed there was no evidence the staff were completing assessments of the access site.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>45739</p> <p>Licensure Reference Number 175 NAC 12.006.12(D)(vi)</p> <p>Based on observation, record review, and interview; the facility failed to ensure insulin pens were dated when opened for Residents 5 and 21. The sample size was 5 and the facility census was 34.</p> <p>Findings are:</p> <p>Review of the facility policy Proper Insulin Pen Administration, undated revealed the following:</p> <ul style="list-style-type: none"> -staff were to document an open date on the insulin pen, -a new safety pen needle would be screwed or clicked on, -the needle would be primed with 2 units of insulin to remove any air, -the dial would be turned to the number of insulin units needed, -the needle would be inserted into the skin and the button pressed to deliver the dose, -the pen would be held at the injection site for 10 seconds (allowing the full dose to be injected), then removed, and -the used pen needle would be removed for proper disposal in a sharp's container. <p>Review of Resident 21's medication orders active as of 10/15/24 revealed an order for Basaglar (a long-acting insulin) at bedtime and Novolog (short-acting) insulin with meals (3 times per day) both had an order date of 1/31/24.</p> <p>Review of Resident 5's medication orders active as of 10/15/24 revealed an order for Basaglar Insulin at bedtime ordered 1/31/24.</p> <p>Observation on 10/15/24 at 7:20 AM with Registered Nurse (RN)-P revealed RN-P obtained Resident 21's insulin pen's out of the medication cart for administration. Neither the Basaglar or the Novolog insulin pens had an open date documented.</p> <p>Observation on 10/15/24 at 1:50 PM with RN-P pulled Resident 5's Basaglar insulin pen out of the medication cart and no open date was found documented on the pen.</p> <p>Interview on 10/15/24 at 7:20 AM with RN-P confirmed there was no open date documented on the insulin pens for Resident 21 and there should have been an open date documented. Further interview on 10/15/24 at 1:50 PM confirmed Resident 5's insulin pen did not have an open date documented and staff were to document an open date on the pen.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 10/15/24 at 2:50 PM with the Administrator and the Director of Nursing confirmed insulin pens were to have an open date documented.</p>

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician.</p> <p>51391</p> <p>Licensure Reference Number 175 NAC 12-006.04(B)(ii)(3)</p> <p>Based on record review and interview: the facility failed to employ a qualified Dietary Manager (DM). This had the potential to affect food service provided to all residents who were served food from the kitchen. The total sample size was 26 and the facility census was 34.</p> <p>Findings are:</p> <p>A. Review of the facility Job Description: Dietary Manager dated 12/27/2021 revealed the DM would direct the overall operation of the Dietary Department in accordance with current applicable federal, state, local standards, guidelines, and regulations, governing the facility. The DM was to assure that quality nutritional services would be provided daily, and the dietary department would be maintained in a clean, safe, and sanitary manner. Duties and Responsibilities of the DM included:</p> <ul style="list-style-type: none"> -Plan, develop, organize, implement, evaluate, direct the dietary department, programs, and activities. -Coordinate dietary services and activities with other related departments -Receive scheduled consultations from a qualified dietitian/nutritional professional. -Develop and maintain written dietary policies and procedures. -Interview residents or family members, as necessary, to obtain diet history. Visit residents periodically to evaluate the quality of meals served, likes and dislikes. -Inspect food storage rooms, utility/janitorial closets for upkeep and supply control. -Review dietary requirements of each resident admitted to the facility, as may be required, and assist the physician in planning for the resident's prescribed diet plan. -Review diet plans and menus to assure they are in compliance with the physician's orders. -Assure all dietary staff complete required compliance training and process. <p>Required education requirements for DM position:</p> <ul style="list-style-type: none"> -Must have training in cost control, food management and diet therapy. <p>(continued on next page)</p>		

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<p>F 0801</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-Must be willing to complete CDM course within the first year of employment if person does not hold educational requirement</p> <p>-Must be knowledgeable of laws, regulations, and guidelines that pertain to long-term care.</p> <p>B. Review of DM-H employee file revealed no evidence DM-H had completed the required training/education for the DM position.</p> <p>During an interview on 10/9/24 at 8:50 AM, DM-H, confirmed that DM had not been trained or taken required classes.</p> <p>An interview with the facility Administrator on 10/9/24 at 10:15 AM, confirmed the DM had not been trained or taken the required classes.</p>		

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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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>51391</p> <p>Licensure Reference Number 175 NAC 12-006.11E</p> <p>Based on observations, record review and interview; the facility failed to maintain the kitchen in a clean and sanitary manner and failed to maintain food temperatures to prevent the potential for food borne illness. This had the potential to effect all residents who ate food from the kitchen. The facility census was 34.</p> <p>Findings are:</p> <p>A. Review of the undated Monthly and Daily Cleaning Checklist for the cooks and aides revealed the Cooks and Aides had cleaning duties daily and monthly for day and night shift.</p> <p>B. The Dietary Safety and Sanitation Audit Completed by the Registered Dietitian, (RD), on 10/8/24, revealed the following:</p> <ul style="list-style-type: none"> -Dry storage area floor was a bit dirty. -Spills were noted down the front and sides of the steam table. -The shelf below the steam table was dusty/dirty, containers were dirty inside and out. -Floors in the kitchen remained dirty throughout. <p>C. An observation on 10/09/24 at 8:29 AM revealed the following:</p> <ul style="list-style-type: none"> -Noted dried on foods to the side and front of the stove and dried on foods to the back wall behind the prep table for toast. -The kitchen floor had dark, dried splatter spots with a dark slimy appearance. -The serving carts that were not being used to serve breakfast had crumbs on them and dried white spots. -The shelves under the prep table and steam table had crumbs on them. <p>D. An observation on 10/10/24 at 11:30 AM revealed the following:</p> <ul style="list-style-type: none"> -The kitchen floor had dark, dried, splatter spots with a dark slimy appearance covering the entire kitchen floor, included the floor where dried foods were stored. -A folded broken down box was on the floor under the prep table by the stove and on the floor by the back wall of the kitchen. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-The side and front of stove had layers of dried, caked on food.</p> <p>-The wall behind prep table for toast had white colored, dried on food.</p> <p>-There were brown and white colored crumbs on the containers under the steam table and the shelves under the food preparation table.</p> <p>-The side and back of the steam table had dried on food.</p> <p>-The top of the steam table had water spots.</p> <p>An interview with the Dietary Manager, (DM-H), on 10/09/24 at 8:50 AM, verified that the kitchen floor had not been cleaned very well because the base board and edges of the kitchen floor had not been completed yet.</p> <p>An interview with Cook, (C-M), verified that the kitchen floors are to be mopped daily and this had not been done.</p> <p>An interview with the Administrator on 10/10/24 from 2:30 PM to 3:00 PM verified the following:</p> <p>-The kitchen had been remodeled, and the base board and edging to the kitchen floor had not been finished.</p> <p>-When the completed Dietary Safety and Sanitation Audit is received from the RD, it is the expectation of the DM to fix the problems when report received.</p> <p>E. Review of the undated facility form Guidelines for Food Temperatures revealed the following:</p> <p>-Food temperatures were taken and recorded prior to each meal service and food was reheated/cooled to ensure proper serving temperatures prior to each meal service. -Periodically temperatures were to be taken at the end of the meal service to ensure temperatures were held within acceptable ranges.</p> <p>The following procedure for checking the temperatures of food was identified:</p> <p>-Food temperatures were to be recorded on the meal temperature form.</p> <p>-To correctly take temperatures, the food thermometer was inserted into the center or thickest part of food for at least 15 seconds (or per instructions of the thermometer) and the thermometer was not to touch the sides or the bottom of the pan or the bone in the meat.</p> <p>-If temperatures were not within recommended guidelines, food/fluids were reheated/chilled until acceptable temperatures were achieved prior to service.</p> <p>-Hot foods which could be potentially hazardous were served at a temperature above 140 degrees Fahrenheit (F).</p> <p>-Cold foods were held at or below 41 degrees F.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>F. Review of the undated facility form Safe Storage Order and Final Cooking Temperatures revealed the following guidelines:</p> <ul style="list-style-type: none"> -For food safety, stored foods were at a temperature of 41 degrees F. or below and foods were cooked to the listed internal temperature: -Ready to eat foods, produce and already cooked foods, fish and eggs were to be served at a temperature of at least 145 degrees F. -All poultry and stuffed products were to be served at a temperature of at least 165 degrees F. <p>G. Review of the October 2024 Meal Temperature Form (form used to document the temperature of individual food items served at each meal) from 10/1/24 to 10/14/24 revealed the dietary staff failed to document any food temperatures for the evening meal on 10/1, 10/2,10/3,10/4, and on 10/6 (5 out of 14 days). In addition, the following food temperatures were documented on the form:</p> <ul style="list-style-type: none"> -10/1 for the breakfast meal, pancakes were served at a temperature of 136 degrees F. For the noon meal the grilled cheese sandwich was served at 135 degrees F., the ground entree was served at 139 degrees F., the puree entree was 136 degrees F., and the puree vegetable was 135 degrees F. -10/2 for the breakfast meal egg bites were served at 135 degrees F. For the noon meal the puree entree was served at 137 degrees F. -10/3 for the breakfast meal the scrambled eggs were served at 137 degrees F. For the noon meal the ground entree had a temperature of 135 degrees F, and the puree entree was 136 degrees F. -10/4 for the noon meal the grilled cheese sandwiches had a temperature of 136 degrees F. -10/10 for the breakfast meal the eggs were served at a temperature of 135 degrees F. <p>H. Observations conducted on 10/10/24 from 11:38 AM to 12:40 PM revealed the following temperatures:</p> <ul style="list-style-type: none"> -12:39 PM the potato salad was 58 degrees F. -12:31 PM The puree chicken was 136 degrees F. <p>An interview with Dietary [NAME] (DC)-S and the Dietary Manager (DM) on 10/16/24 at 8:20 AM confirmed the temperature of the potato salad should have been served and maintained at 41 degrees F. or less and the puree chicken should have been served and maintained at a minimum temperature of 165 degrees F.</p> <p>29638</p> <p>I. Review of the facility Logbook Documentation revealed the following steps for cleaning and maintaining the facility ice machine:</p> <ul style="list-style-type: none"> -check the filter to ensure correctly installed and replace as needed. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-sanitize the interior of the machine per manufacturer's directions.</p> <p>-clean out and sanitize the ice bin.</p> <p>-check the drain hose and make sure it is connected securely.</p> <p>-check the filter date and change as needed.</p> <p>J. Review of a Work History Report indicated the ice machine was last cleaned and provided maintenance on 7/2/24 (3 months earlier).</p> <p>K. Observations of the ice machine on 10/10/24 at 11:22 AM revealed the following:</p> <p>-the linoleum under the ice machine was missing, and the machine was positioned directly on a concrete floor. The floor had chips/gouges and remnants of glue which had been in use to affix the linoleum to the floor (not a cleanable surface).</p> <p>-the floor drain underneath of the ice machine was partially covered by a grate/cap. The perimeter of the drain opening had a gray/milky, slime like appearance.</p> <p>-a drainage tube from the ice machine was propped onto the cap/grate over the floor drain. The tube had a constant flow of water which also had a gray/milky discoloration.</p> <p>-filter on the side of the machine was heavily coated with a gray fuzzy substance that resembled dust/debris.</p> <p>An interview with the Administrator on 10/10/24 at 11:53 AM revealed the maintenance staff managed cleaning and maintenance of the ice machine.</p> <p>The Administrator was uncertain as to when it was last cleaned and when it was due to be cleaned/maintained again.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360</p> <p>Licensure Reference Number 175 NAC 12-006.18(B)(C)(D)</p> <p>Based on observation, interview, and record review; the facility failed to implement the required Personal Protective Equipment (PPE- items such as gowns, gloves, face shield that are worn to protect care givers during the provision of care and to protect other residents from being exposed to potential harmful communicable disease/s) during the provision of care for Residents 12 and 235, failed to implement a mitigation plan to prevent potential water borne illness, failed to place a protective barrier for medications taken to resident care areas and then returned to the medication cart after use for Resident 21, failed to complete hand hygiene during the administration of medications and the delivery of room trays, and failed to store oxygen equipment in a manner to prevent potential cross-contamination for Resident 85.</p> <p>Findings are:</p> <p>A. Review of the facility policy Infection Control Prevention and Control Program dated 9/2017 revealed the facility had a facility wide effort involving all disciplines and individuals and was an integral part of the quality assurance and performance improvement program.</p> <p>The elements of the Infection Prevention and Control Program consisted of coordination/oversight, policies/procedures, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety.</p> <p>Review of the facility policy Standard and Transmission-Based Precautions dated 3/2024 revealed the following:</p> <p>-It was facility policy to implement infection control measures to prevent the spread of communicable diseases and conditions. It was appropriate to individualize decisions regarding resident placement, balancing infection risks with the need for more than one occupant in the room, the presence of risk factors that increased the likelihood of transmission, and the potential for adverse psychological impact on the infected or colonized (when a bacteria or other organism is present but not currently causing disease) resident. It was therefore appropriate to use the least restrictive approach possible that adequately protected the resident and/or others.</p> <p>-Enhanced Barrier Precautions (EBP- set of infection control guidelines using PPE to reduce the spread of Multi-Drug Resistant Organisms (MRDO's- germs that are resistant to many antibiotics) in nursing homes, were used in conjunction with standard precautions and the expanded the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MRDO's to staff hands and clothing then indirectly transferred to residents or from resident to resident.</p> <p>-The use of gown and gloves for high-contact resident care activities were indicated, when Contact Precautions did not otherwise apply, for nursing home residents with Wounds and/or indwelling medical devices regardless of known MRDO infection or colonization.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>-MRDO's for which the use of EBP applied were based on local epidemiology (study of the distribution, causes, and control of health-related events aimed to prevent and control them). At a minimum, they included resistant organisms targeted by the Center for Disease Control (CDC) but could also include other epidemiologically important MRDO's.</p> <p>-Examples of high-contact resident care activities that required gown and glove use for EBP included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs and/or assisting with toileting, device care and use, including central vascular lines, indwelling urinary catheters, feeding tubes, tracheostomy/ventilator, and wound care.</p> <p>B. Review of Resident 12's Minimum Data Set (MDS-federally mandated comprehensive assessment use to develop resident care plans) dated 7/9/24 revealed the resident was dependent for toileting hygiene and received assistance with transfers and bed mobility. The resident had complex medical conditions including heart failure and respiratory failure and received oxygen therapy and hospice services.</p> <p>Review of Resident 12's Care Plan with a revision date of 8/10/24 revealed the resident had a history of Vancomycin Resistant Enterococci (VRE-a clinically significant antibiotic resistant infection) and required partial to moderate assistance with toileting transfers, was dependent for toileting hygiene, required partial to moderate assistance with going from sitting to lying down and lying down then sitting up, and was frequently incontinent of bladder and occasionally of bowel. In addition, staff were to clean their hands, including before entering and when leaving the room, and staff should wear gloves and a gown for the high contact care activities including dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, assisting with toileting and device care/wound care.</p> <p>During an observation of the provision of care for Resident 12 on 10/10/24 at 10:28 AM Nurse Aide (NA-L) entered the resident's room (did not put on gloves or a gown) explained to resident that the aide would assist the resident to get up, dressed, and toileted. NA-L then assisted the resident to sit up in bed, removed an oxygen cannula (device that sits in the residents' nose/nares to deliver oxygen) and placed the cannula over the oxygen concentrator, provided extensive assist to lift the residents legs out of bed, applied gait belt (safety device used to support and provide safety during transfers and ambulation) to the resident and assisted the resident to walk to bathroom using a walker. MA-L then entered the bathroom and put on gloves and assisted the resident to pull down pants and sit on toilet. NA-L removed a slightly wet incontinence product, placed it in the trash, removed the gloves and washed hands, then without gloves retrieved clean clothing from the closet and a clean pull-up from a drawer in the bathroom. NA-L put on clean gloves and assisted the resident to put on the clean incontinence product, pants, shoes, and a shirt. NA-L then assisted the resident to stand and performed perineal-care (washing and caring for the genital and rectal areas of the body) using disposable wipes, then pulled up the incontinent product and pants. NA-L then removed the gloves and walked with resident back to bed. NA-L then assisted the resident to sit on the edge of the bed, removed shoes and socks (resident request) and assisted resident back into bed using extensive assist to lift legs (all while not wearing a gown or gloves). NA-L then reapplied the oxygen cannula and covered the resident with several blanket (again while not wearing gloves or a gown).</p> <p>Review of the undated New Hire and Refresher Education list provide by the facility for Nurse Aides revealed the refresher training included education on Infection Control: Enhanced Barrier Precautions.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 10/15/24 at 10:12 AM the facility Infection Preventionist confirmed that Resident 12 was on EBP and staff are to wear gown and gloves during hands on care including transfers, dressing, and toileting/toileting hygiene.</p> <p>During an interview on 10/15/24 at 2:51 PM The Director of Nursing (DON) confirmed that Resident 12 was on EBP for a history of a MRDO and staff were to wear a gown and gloves during all care provision that required hands on care such as transfers and toileting assistance.</p> <p>C. Review of the facility policy Water Safety Management Program (Legionella-bacteria causing a pneumonia like illness that resides in [NAME] environments such as lakes, [NAME], reservoirs, and man-made water systems) with a revision date of 1/2022 revealed the following:</p> <ul style="list-style-type: none"> -the facility provided maintenance protocol guidelines for plant operations related to water safety management to ensure the reduction in potential growth of Legionella organisms in the water system of the facility. -The facility developed and maintained a water management program that included a team, a description of the facility water system, a water system diagram that described areas where legionella could grow, and spread with potential triggers and sources of bacteria growth. -The facility established control measures monitoring temperature and disinfectant levels to prevent water stagnation and bacteria growth. <p>During an interview on 10/15/24 at 2:18 PM the Maintenance Supervisor confirmed the facility did not have a consistent plan for flushing of unused water systems to prevent water stagnation and the potential growth of water borne pathogens.</p> <p>During an interview on 10/16/24 at 7:39 AM the Maintenance Supervisor confirmed that a water management mitigation plan had not been implemented.</p> <p>51391</p> <p>D. Review of Resident 235's MDS dated [DATE] revealed the resident had a complex medical condition, surgical wound care, (intravenous) IV medication and antibiotics.</p> <p>Review of Resident 235's Care Plan with a date of 9/23/24 revealed the resident had a surgical site to the right great toe and had received IV medications. The resident was on EBP and staff were to wear gown and gloves for high contact care activities including wound care.</p> <p>During an observation of the provision of care for Resident 235 on 10/9/24, at 1:18 PM revealed a sign on the door that stated Enhanced Barrier Precautions. Further observations on 10/9/2024 at 1:18 PM revealed Licensed Practical Nurse (LPN-A) stood at the edge of bed with gloves on, no gown and removed a bandage from the resident's right foot, completed a treatment, then reapplied the bandage to right great toe. LPN-A removed the gloves and then performed hand hygiene.</p> <p>During an interview with Resident 235 on 10/9/24 at 1:34 PM, the resident reported staff only wore gloves, and no gowns, when dressings were changed to the right foot.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview with Registered Nurse (RN)-Q on 10/10/24 at 8:36 AM, RN-Q, verified Resident 235 was on EBP and gown and gloves were to be worn with wound treatments.</p> <p>During an interview with LPN-A on 10/10/24 at 9:41 AM, LPN-A, verified that when the dressing change was completed on 10/9/24 to Resident 235's right foot, LPN-A had a pair of gloves on, and no gown. LPN-A verified that Resident 235 was on EBP and gloves and gown should have been worn.</p> <p>29638</p> <p>E. Review of the facility policy Hand Hygiene with a date of 6/1/21 revealed hand hygiene was defined as a general term for hand washing, antiseptic hand wash and alcohol-based hand rub. Hand hygiene was identified as the most effective way to prevent the spread of infection. Hand hygiene was to be performed:</p> <ul style="list-style-type: none"> -before and after contact with residents. -after contact with blood, body fluids, visibly contaminated surfaces or after contact with objects in the resident's room. -after removing personal protective equipment. -before preparing or handling medications. -before and after assisting a resident with meals. <p>F. Observations of Resident 85's room throughout the survey revealed the following:</p> <ul style="list-style-type: none"> -10/9/24 at 9:32 AM an oxygen concentrator was observed next to the resident's bed. The tubing and nasal cannula attached to the concentrator was lying directly on the floor behind the concentrator. -10/10/24 at 8:32 AM the oxygen tubing and nasal cannula attached to the oxygen concentrator was draped across the bedside table and coiled on the floor. -10/15/24 at 8:40 AM the oxygen tubing and nasal cannula attached to the oxygen concentrator was lying across the resident's bed. <p>During an interview on 10/16/24 at 9:38 AM, Licensed Practical Nurse (LPN)-O confirmed the resident's oxygen tubing/cannula were to be stored in a bag on the side of the resident's oxygen concentrator.</p> <p>G. Observation of the breakfast room-tray meal service on 10/10/24 from 8:38 AM to 8:45 AM revealed the following:</p> <ul style="list-style-type: none"> -8:38 AM Dietary Aide (DA)-B entered the 400 corridors with a cart containing room trays. DA-B positioned the cart in the center of the corridor. -8:39 AM without performing hand hygiene, DA-B entered resident room [ROOM NUMBER] and <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>placed the room tray on the bedside table in front of the resident. DA provided set-up assist including helping the resident with a clothing protector. DA-B exited the room and returned to the food cart. DA-B failed to perform hand hygiene.</p> <p>-8:40 AM DA-B entered resident room [ROOM NUMBER] with meal tray and provided tray set-up then exited room. DA-B again failed to perform hand hygiene.</p> <p>-8:41 AM DA-B entered resident room [ROOM NUMBER] with a room tray. DA assisted the resident with setting up the meal tray and placing on a clothing protector then exited the room without performing hand hygiene.</p> <p>-8:43 AM DA-B entered room [ROOM NUMBER] and delivered a room tray. After exiting the resident room, the staff member still without completing hand hygiene took the cart back to the kitchen.</p> <p>Observations of the noon, room-tray meal service on 10/10/24 from 12:32 PM to 12:39 PM revealed the following:</p> <p>-12:32 PM DA-B exited the kitchen with a cart containing room trays for the noon meal and positioned the cart on the 400 corridors.</p> <p>-12:33 PM DA-B without performing hand hygiene, entered room [ROOM NUMBER] with a meal tray. DA-B placed the tray on a bedside table. DA-B moved several resident items which included a box of Kleenex, a TV remote, and the water jug to make room for the tray. Staff then provided set-up assistance for the resident before exiting the room.</p> <p>-12:35 PM DA-B still without completing hand hygiene, entered room [ROOM NUMBER] and placed room tray on the bedside table. DA-B re-arranged the resident's personal items on the bedside table to make room for the room tray then assisted the resident with meal set-up.</p> <p>-12:36 PM DA-B re-entered room [ROOM NUMBER] with a meal tray for the other resident in the room. DA-B provided the resident with set-up assistance and without performing hand hygiene exited the room.</p> <p>-12:37 PM DA-B entered room [ROOM NUMBER] and delivered the final room tray. DA-B exited the resident's room and returned to the kitchen with the cart still without performing any hand hygiene.</p> <p>During an interview on 10/10/24 at 1:00 PM, DA-B indicated the dietary staff had received no additional training regarding hand hygiene when delivering room trays. In addition, DA-B confirmed going in and out of the resident rooms to deliver room trays for the breakfast and the noon meal and not completing any hand hygiene.</p> <p>Observations of the breakfast, room tray meal service on 10/15/24 from 8:52 AM to 8:57 AM, revealed DA-N delivered room trays to residents in rooms 432, 434 and 436. DA-N failed to complete any hand hygiene throughout this observation and before returning to the kitchen.</p> <p>During an interview on 10/15/24 at 3:00 PM, the facility Administrator and the interim DON confirmed the Dietary staff should have performed hand hygiene before entering and then again when exiting the resident's rooms.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>45739</p> <p>H. Observation on 10/15/24 at 7:20 AM with RN-P revealed RN-P put on a pair of gloves without performing hand hygiene and opened the medication cart to obtain medications for Resident 21. RN-P gathered a nasal spray, an eye drop, an inhaler, Novolog insulin pen (a short-acting insulin), and Basaglar insulin pen (a long-acting insulin) and placed them on the medication cart. The Basaglar pen did not have enough insulin for the administration. RN-P needed a new Basaglar insulin pen, so RN-P placed all medications back into the medication cart, locked the cart, removed their gloves, and walked away. No hand hygiene was observed being performed. RN-P returned, put on new gloves without performing hand hygiene, and unlocked the medication cart. RN-P obtained all the medications from the medication cart then knocked and entered Resident 21's room. RN-P placed the medications onto Resident 21's bedside table without a barrier. RN-P handed Resident 21 the nasal spray to self-administer then the inhaler and placed them back onto the bedside table when Resident 21 was finished. RN-P still wearing the same pair of gloves instilled the eye drop into both of Resident 21's eyes and placed the eye drop back onto Resident 21's bedside table. RN-P, still wearing the same pair of gloves obtained the insulin off the bedside table and administered the insulin's one at a time. RN-P still wearing the same pair of gloves, gathered the medications off the bedside table, exited the resident room, and placed the medications on top of the medication cart without a barrier. RN-P still wearing the same pair of gloves unlocked and opened the medication cart and put the medications away. RN-P removed their gloves. No hand hygiene was observed being performed.</p> <p>Interview on 10/15/24 at 7:30 AM with RN-P confirmed there was no barrier placed onto Resident 21's bedside table prior to placing medications on it, gloves were not changed after administering medications, and hand hygiene was not completed after removing gloves.</p> <p>Interview on 10/15/24 at 2:50 PM with the Administrator and the DON confirmed a barrier should be placed before placing medications that would return to the medication cart onto the resident's bedside table, gloves should be changed after administering medications, and hand hygiene should be performed after removing gloves.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/16/2024
NAME OF PROVIDER OR SUPPLIER Wayne Countryview Care and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 811 East 14th Street Wayne, NE 68787	

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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51391</p> <p>Licensure Reference Number 175 NAC 12-006.19</p> <p>Based on observations, record review and interviews: the facility failed to maintain a pest free environment in Resident 235's Room and the facility kitchen. The total sample size was 26 and the facility census was 34.</p> <p>Findings are:</p> <p>A. Review of the facility Pest Control Policy dated 2007 revealed the facility had measures in place to maintain pest control in the facility and outer areas of the facility. The facility had a contract with a pest control company to do monthly scheduled inspection for pest and rodent control.</p> <p>B. During an interview with Resident 235 on 10/9/24 at 1:34 PM, resident stated there were tiny black bugs in the bathroom in the little basin by the sink.</p> <p>C. An observation on 10/9/24 at 1:37 PM revealed tiny black bugs were in resident 235 toothbrush basin, some of the bugs were moving around.</p> <p>An observation on 10/10/24 at 7:46 AM, noted a yellow basin in the bathroom with tiny black bugs, none of the bugs were moving.</p> <p>An observation on 10/10/24 at 11:30 AM, 2 windows in the kitchen had dead spiders, dust, and spider webs noted. Clean water pitchers were in front of the one window and a bread rack with loaves of white bread were in front of the other window. A screen from one of the windows had been removed and sitting on the window ledge.</p> <p>An observation on 10/15/24 at 8:00 AM noted that Resident 235 was moved to room [ROOM NUMBER]B, no bugs were noted in the bathroom or the little basin.</p> <p>An interview on 10/10/24 at 11:30 AM, with Cook, (C-M), reported that the screen had been removed to get cleaned, C-M was unable to verify who was to clean the screen or windows.</p> <p>An interview on 10/10/24 at 11:30 AM, with Dietary Manager, (DM-H), verified that windows and screens in the kitchen had not been cleaned, dead spiders, dust and spider webs were evident, and need cleaned.</p> <p>D. A review of the Service Summary Report dated 10/9/24, revealed Pest Control was in the building, interior rodent traps were serviced with little to no catches to report.</p> <p>E. An interview with the Administrator on 10/15/24 at 8:00 AM revealed that Resident 235 was moved to room [ROOM NUMBER] B the afternoon of 10/14/24 due to the bugs in room [ROOM NUMBER] A, Resident 235's prior room. Administrator further revealed bugs had been noted in other areas of the building also.</p>