STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285144	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Blue Hill	414 North Willson Street Blue Hill, NE 68930

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Based on record review and interview the facility failed to ensure that the resident/resident representative was provided with the required Centers for Medicare and Medicaid Services (CMS) notifications of the ending of their Medicare Part A skilled services (a program that covers the cost of short-term skilled nursing facility (SNF) care for up to 100 days in a SNF). This prevented the resident/resident representative from making an informed decision regarding their choice for further care and financial options, and of the right to appeal the decision. This affected 3 of 3 residents reviewed (Residents 30, 91, and 90). The facility census was 38. Findings are: Record review of the undated facility Admission Agreement revealed that under written order from a physician, and as required in the comprehensive plan of care, the Facility will provide specialized rehabilitative services such as physical, occupational, and speech therapy by qualified personnel. The facility participates in the Medicare Program and is authorized to provide care and services to residents who are eligible for Medicare benefits. If the Resident is deemed eligible for Medicare benefits or Medicaid assistance, the laws and regulations governing those programs will control this Agreement. The undated Attachment N titled Form Instructions for the Notice of Medicare Non-Coverage (NOMNOC) revealed that a Medicare provider must deliver a completed copy of the Notice of Medicare Non-Coverage to beneficiaries receiving covered skilled nursing services (Medicare Part A skilled services). The NOMNOC must be delivered at least two calendar days before Medicare covered services end. The undated Attachment O titled Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage (SNF ABN) revealed that it is notification that the nursing facility believes that the resident's care does not meet the Medicare coverage requirements. The resident may have to pay out of pocket for care. The attachment contained a line for documenting the date that out of pocket charges for care may begin, and an estimate of the cost of services. A. Record review of the Admission Record dated 4/16/25 for Resident 30 revealed that Resident 30 admitted into the facility on [DATE]. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Resident Clinical Census (a record of the resident's dates of stay in the facility listing the payer type for the dates) dated 4/16/25 revealed that Resident 30 had Medicare Part A as the primary payer for their nursing skilled services beginning on 11/1/24. The resident's last day of Medicare Part A services was 1/16/25. The census revealed that Resident 30 remained in the facility with non-Medicare payer beginning on 1/17/25. (Resident 30 used only 77 of the 100 days of their Medicare Part A benefits). Record review of the Progress Note dated 1/15/25 at 9:58 AM for Resident 30 revealed that Resident 30's speech therapy was addressing recall, reasoning, and word finding. The note also indicated speech therapy would discontinue the following day. Record review of the Speech Therapy Discharge Summary dated 1/16/25 for Resident 30 revealed that speech therapy for Resident 30 was discontinued on 1/16/25 due to Resident 30 reaching their highest practical level/maximum potential achieved (a provider initiated discharge from Medicare Part A services). Record review of the General Notes Report dated 4/16/25 for Resident 30 revealed that a NOMNOC was issued to Resident 30 due to meeting their maximum potential in therapy. Record review of the medical record for Resident 30 revealed no NOMNOC or SNF ABN for Resident 30. Interview on 4/16/25 at 8:47 AM with the facility's Business Office Manager (BOM) confirmed that the facility did not have the NOMNOC for Resident 30 and that an SNF ABN was not provided to Resident 30. Interview on 4/16/25 at 2:30 PM with the Facility Administrator (FA) confirmed that Resident 30 was discharged from Medicare Part A services due to reaching their maximum potential and that it was a facility initiated discharge from Medicare Part A services. The FA confirmed that Resident 30 did not discharge from Medicare Part A services voluntarily. The FA confirmed that Resident 30 was required to receive the beneficiary notifications, NOMNOC and SNF ABN, for the end of their Medicare Part A services. The FA confirmed that the facility did not provide the beneficiary notifications to Resident 30 as required. B. Record review of the Admission Record dated 4/16/25 for Resident 91 revealed that Resident 91 admitted into the facility on [DATE] and discharged from the facility on 1/3/25. Record review of the Resident Clinical Census dated 4/16/25 for Resident 91 revealed that Resident 91 had Medicare Part A as the primary payer for their skilled nursing services beginning on 12/4/24. The last day of Medicare Part A services was 1/2/25. Resident 91 discharged from the facility on 1/3/25. (Resident 91 used only 31 of the 100 days of their Medicare Part A benefits). Record review of the Physical Therapy Discharge Summary dated 1/2/25 for Resident 91 revealed that physical therapy for Resident 91 discontinued on 1/2/25 due to all therapy goals being met/achieved (a provider initiated discharge from Medicare Part A services). The Discharge Summary revealed that Resident 91 will discharge home with no services. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of the Progress Note dated 1/2/25 at 10:13 AM for Resident 91 revealed that Resident 91 is ready for discharge. Orders for discharge from the facility were requested from the resident's physician. Record review of the Progress Note dated 1/3/25 at 2:27 PM for Resident 91 revealed that Resident 91 discharged out of the facility and moved back to an Assisted Living Facility. Record review of the medical record for Resident 91 revealed no NOMNOC for Resident 91. Interview on 4/16/25 at 2:30 PM with the FA confirmed that Resident 91's discharge from Medicare Part A services was a facility initiated discharge. The FA confirmed that Resident 91 was required to receive the NOMNOC beneficiary notification since they were discharging from the facility immediately at the end of their Medicare Part A services. The FA confirmed that the facility did not provide the beneficiary notification to Resident 91 as required. C. Record review of the Admission Record dated 4/16/25 for Resident 90 revealed that Resident 90 admitted into the facility on [DATE] and discharged from the facility on 2/26/25. Record review of the Resident Clinical Census dated 4/16/25 for Resident 90 revealed that Resident 90 had Medicare Part A as the primary payer for their skilled nursing services beginning on 1/8/25. The last day of Medicare Part A services was 2/12/25. (Resident 90 used only 32 of the 100 days of their Medicare Part A benefits). Resident 90 remained in the facility with private pay for care beginning on 2/13/25 until their discharge from the facility on 2/26/25. Record review of the Speech Therapy Discharge Summary dated 2/13/25 for Resident 90 revealed that speech therapy for Resident 90 was discontinued on 2/13/25 due to Resident 90 reaching their highest practical level/maximum potential achieved (a provider initiated discharge from Medicare Part A services). Record review of the Progress Note dated 2/3/25 at 11:36 AM revealed that the Power of Attorney for Resident 90 was contacted regarding an update on Resident 90 and discussion of the plans for Resident 90 after therapy discharges the resident. Therapy is telling the resident that the resident has hit a plateau. Record review of the medical record for Resident 90 revealed no NOMNOC or SNF ABN for Resident 90. Interview on 4/16/25 at 2:30 PM with the FA confirmed that Resident 90 was discharged from Medicare Part A services due to reaching their maximum potential and that it was a facility initiated discharge from Medicare Part A services. The FA confirmed that Resident 90 did not discharge from Medicare Part A services voluntarily. The FA confirmed that Resident 90 was required to receive the beneficiary notifications, NOMNOC and SNF ABN, for the end of their Medicare Part A services. The FA confirmed that the facility did not provide the beneficiary notifications to Resident 90 as required.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.19(A) Licensure Reference Number 175 NAC 12-006.19(B) Based on observation, record review, and interview, the facility failed to ensure that rooms were clean and maintained for 5 of 16 residents observed (Residents 33, 10, 15, 2, and 29). The facility census was 38. Findings are: Record review of the facility's undated Admission Agreement Attachment 3 titled Resident Rights revealed that the resident has the right to a dignified existence. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The resident has the right to a safe, clean, comfortable, and homelike environment. The facility must provide a safe, clean, comfortable, and homelike environment. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior including adequate and comfortable lighting levels in all areas. A. Observation on 4/14/25 at 7:57 AM in the bathroom of Resident 33 revealed that the bathroom was dark. A dull light on the left side above the sink was on. The light on the right side above the sink was not functioning. The ceiling light was dull. Observation on 4/16/24 at 12:47 PM in the room of Resident 33 with the Facility Administrator (FA) confirmed that the light level in the resident's bathroom was low. The FA confirmed that the light on each side of the sink is now working but dull with the yellowed covers on them. The FA confirmed that the light in the ceiling is not a high enough [NAME] bulb to provide sufficient lighting. B. Observation on 4/14/25 at 8:00 AM in the room of Resident 10 revealed that there was an approximately 1 inch gap between the bedroom carpet and the bathroom vinyl floor per visual measurement. The threshold to cover the gap was missing. Observation on 4/16/25 at 12:48 PM in the room of Resident 10 with the FA confirmed that the gap between the carpet of the resident room and the bathroom floor entry needed to be repaired. The FA confirmed that the threshold was missing and needed to be fixed. C. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 4/14/25 at 8:11 AM in the bathroom of Resident 15 revealed that the water in the sink was not draining as the water was running. The water remained in the sink after the water was shut off. Observation on 4/16/25 at 12:42 PM with the FA confirmed that the bathroom sink of Resident 15 was not draining as it should and that it was in need of repair. D. Observation on 4/14/25 at 9:47 AM in the bathroom of Resident 2 revealed that the bathroom exhaust vent cover was soiled with dark dusty debris. The inside of the toilet bowl was stained with scratches and black marks. Observation on 4/16/25 at 12:51 PM in the room of Resident 2 with the FA confirmed that the bathroom exhaust vent was soiled with gray fuzzy debris and rust-like debris and needed to be cleaned. The FA confirmed that the toilet bowl was scratched and needed to be replaced. E. Observation on 4/14/25 at 1:03 PM in the bathroom of Resident 29 revealed that the bathroom exhaust vent was soiled with fuzzy dark debris. Observation on 4/16/25 at 12:52 PM in the room of Resident 29 with the FA confirmed that the bathroom exhaust vent is soiled with gray fuzzy debris and rust-like debris and needed to be cleaned. Interview on 4/16/25 at 12:53 PM with the FA confirmed that the facility needed to address the cleaning and maintenance issues observed for Residents 33, 10, 15, 2, and 29.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 Licensure Reference Number 175 NAC 12-006.02(H) Based on record reviews and interviews, the facility failed to ensure that interventions were put into place to prevent further potential abuse or self-harm for 1 (Resident 190) of 1 sampled residents. The facility census was 38. Findings are: Record review of the policy Compliance with Reporting Allegations/Neglect Exploitation dated 10/2023 state the policy of this facility is to report all allegations of abuse/neglect/exploitation or mistreatment, including injuries of unknown sources and misappropriation of resident property are reported immediately to the Administrator of the facility and to other appropriate agencies in accordance with current state and federal regulations within prescribed time frames. The procedure states the following procedures will be initiated: 1. The licensed nurse will; -Respond to the needs of the resident and protect him/her from further incident, -Notify the Administrator or designee, -Notify the attending physician, family or legal guardian, and the medical director, -Document actions in the medical record, -Complete an incident report, and -Revise the resident's care plan if the residents medical, nursing, physical, mental or psychosocial needs or preferences change as a result of an incident of abuse. Record review of the Facility Assessment approved and dated 04/08/2025 by the facility administrator revealed on page 7 that the facility provides care for diseases/conditions and physical/cognitive disabilities including psychiatric/mood disorders such as psychosis (hallucinations, and delusions), impaired cognition, mental disorder, depression, bipolar disorder, Schizophrenia, post traumatic stress disorder, anxiety disorder, behavior that needs interventions, etc. Record review of the Medical Diagnoses revealed Resident 190 was diagnosed with schizoaffective disorder (bipolar type; mania and depression), non-suicidal self-harm, generalized anxiety disorder, borderline personality disorder, suicidal ideations, sleep apnea, insomnia, post-traumatic stress disorder, hypothyroidism, morbid obesity, and depression among others. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the admission Minimum Data Set (MDS, a standardized assessment tool used to evaluate the health status of residents nursing homes which provides a comprehensive overview of a resident's functional capabilities and helps identify potential health issues used for care planning.) dated 7.26.2024 for Resident 190 revealed the resident had a Brief Interview for Mental Status (BIMS-used to assess a resident's cognitive function) of 14 meaning the resident was cognitively intact. During the testing period, Resident 190 was not depressed, sometimes felt lonely or isolated, had a worsening or behavior symptoms compared to the prior assessment but did not wander or reject cares, needed assistance with bathing but was able to most other activities of daily living with supervised assistance or independently, was unable to walk due to safety concerns, was occasionally incontinent of bowel and bladder, and had occasional pain. Medications included Antipsychotics for mood stabilization, antidepressants, and hypoglycemic's to lower blood sugars. Record review of the Incidents by Incident Type dated 04/15/2025 revealed that there were six incidents of self-harm recorded for Resident 190. The dates of the incidents were as follows: 7/30/2024, 7/31/2024, 8/23/2024, 8/29/2024, 9/25/2024, and 10/15/2024. Record review of the Resident Census revealed Resident 190 admitted , transferred and discharged on the following dates; -admitted to the facility on [DATE]. -Transferred to the hospital on 07/31/2024 and readmitted to the facility on [DATE]. -Transferred to the hospital on 08/29/2024 and readmitted to the facility on [DATE]. -Transferred to the hospital on 09/25/2024 and readmitted to the facility on [DATE]. -Transferred to the hospital on 10/16/2024 and discharged from facility on 10/29/2024. Record review of the Nursing Progress Notes printed on 04/16/2025 revealed the following: -7/30/2024 at 9:00 PM revealed Resident 190 had a self-inflicted laceration 3 centimeters (cm) long by 0.3 cm deep to inside of the left arm. Laceration was not actively bleeding. Resident 190 used the fingernails of two fingers on the right hand to cause the injury. The area was cleaned by the charge nurse and a bandage was applied. The progress notes revealed the incident was reported to the physician on 07/31/2024 at 5:00 AM by faxed communication. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-07/31/2024 at 8:47 PM revealed the charge nurse was called to Resident 190's room by a medication aide who revealed Resident 190 was picking on the earlier injury found to the left arm. However, Resident 190 had also self-injured an area of the lower abdomen. Resident 190 was sitting up in bed. The charge nurse noted a laceration to the lower abdomen which was 6 cm by 1.5 cm with slow draining blood. The charge nurse attempted to clean area but Resident 190 would not allow the charge nurse to tend to the wound and continued to pick at wound. At 9:15 PM the charge nurse was able to speak with Resident 190 in the resident's room. After resident refused treatment to new self-inflicted abdominal wound and refused an as needed hydroxyzine from the charge nurse, Resident 190 allowed the charge nurse clean the wounds. The area to the resident's lower abdomen measured 6 cm x 1.5 cm and continued with slow draining of blood. The nurse cleansed the area to the resident's left upper arm, which measured 3 cm in length. When asked why Resident 190 hurt oneself, Resident 190 stated physical pain was better than emotional pain and told the charge nurse(gender) was very sad and wanted to die. The Nursing Assistant had told the charge nurse that Resident 190 was suicidal (wanted to kill self). The charge nurse called the guardian and attending physician for Resident 190. Resident 190 was transferred to a hospital for evaluation and treatment. -08/23/2024 at 7:45 PM revealed the nurse charge was called to Resident 190's room by a nursing assistant and found that Resident 190 had self-inflicted skin abrasion to upper chest with no active bleeding. The areas were measured, cleaned, and covered with a clear dressing. Resident had three areas above chest, one measuring 4 cm x 1.5 cm, 3 cm x 1 cm, and 3 cm x 1 cm. Resident 190 felt anxious at the time and did not think to ask for something for anxiety. The facility started Resident 190 on every 15 minute resident checks. The Director of Nursing (DON) and the Physician were both notified of the incident. -08/29/2024 at 8:01 PM revealed a nursing assistant notified the charge nurse that Resident 190 was cutting their stomach with their nails. When the charge nurse entered the room, Resident 190 was found actively using a piece of plastic to try and cut skin on upper middle abdomen. Resident 190's skin was cut open at the center of upper abdominal region and was bleeding. When the charge nurse asked Resident 190 if (gender) had harmed self, Resident 190 stated, yes and I'm gonna keep doing it. The charge nurse then asked if then asked about Resident 190's feelings and what had made Resident 190 start cutting their skin, Resident 190 had stated, I am just tired of it. Resident 190 was reportedly alert and oriented x 4 with a newly self-inflicted abrasion that was 1 cm in length and 0.3 cm in width. DON, physician, and guardian were notified of incident. Resident 190 was sent to ER via ambulance. -09/25/2024 at 12:00 PM revealed the charge nurse contacted the physician and was told of the injuries to Resident 190's arm which were reportedly significant. The physician called the emergency room and requested Resident 190 be admitted to the psychiatric floor of the hospital. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/15/2024 at 7:50 PM revealed the charge nurse was notified Resident 190 had a pen-like object in Resident 190's left inner biceps (arm). Resident 190 refused scheduled medications and refused to state what (gender) was doing with the pen-like object. Later in the evening, at 10:30 PM another nursing assistant reportedly found Resident 190 scratching (gender) abdomen with a pen-like object. Resident 190 would not reveal what was being done with the pen once again. A skin assessment was completed of Resident 190 and wound measurements completed. The left medial upper arm wound measured 4 cm x 0.5 cm x 0.5 cm. The abdominal wound was not measured due to the refusal of Resident 190 to allow staff to look at the wound. Resident 190's physician was notified at 11:44 PM and orders were received to send Resident 190 to the emergency room . Law enforcement and Emergency Medical Technicians arrived at the facility and the resident was taken to the hospital. Record review of the Care Plan (a document developed for all nursing home residents to help to address both medical and non-medical concerns) printed on 04/15/2025 for Resident 190 revealed that only two updates were added to the care plan to prevent further harm or injuries after the following incidents: 7/30/2024, 7/31/2024, 8/23/2024, 8/29/2024, 9/25/2024, and 10/15/2024. -There was no update to the care plan for Resident 190 after the incidents on 07/30/2024 and 07/31/2024, after Resident 190 returned to the facility following a hospital stay and readmission to the facility on [DATE]. -There was no update to the care plan for Resident 190 after the incident on 08/23/2024. -There was an update to the care plan of Resident 190 added on 08/30/2024, the day after the resident was transferred to the hospital, which stated Resident 190 was to be evaluated by hospital for psychiatric needs. -There was no update to the care plan after Resident 190 was readmitted on [DATE] following an incident on 8/29/2024 and a hospital stay. -There was no update to the care plan for Resident 190 after the incident on 09/25/2024 after Resident 190 returned to the facility following a hospital stay and readmission to the facility on [DATE]. -There was an update to the care plan of Resident 190 added on 10/15/2024, the day before the resident was transferred to the hospital, which stated Resident 190 was to be evaluated for wearing appropriate footwear. -There were no care plan updates that revealed preventative measures related to self-harm either while the resident was in the facility or upon return to the facility from hospital stays. Interview on 04/15/2025 at 3:20 PM with Registered Nurse (RN)-D revealed that care plans are usually updated at the time of the risk meeting and by the care plan coordinator or MDS personnel. RN-D had only been working in the facility about 6 weeks and was still learning the facility processes. Interview on 04/15/2025 at 4:15 PM with the Director of Nursing (DON) who stated that the care plans are updated after incidents and as needed by the DON, MDS coordinator, or nursing staff as needed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 04/16/2025 at 4:10 PM with the Facility Administrator (FA) confirmed no updates were completed in the care plans to prevent further self-harm because the facility didn't want to change any aspects of what the hospital, where Resident 190 had been admitted and released during each hospital stay, had told the facility to do. The FA further confirmed that the facility assessment stated the facility was able to care for residents with the types of disabilities that Resident 190 was diagnosed with and that the facility had not put their own interventions into place to care and prevent further harm to Resident 190.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41938 Licensure Reference Number 175 NAC 12-006.09(H)(vi)(2) Based on observation, record review, and interview the facility failed to provide individualized 1 on 1 activities and engage residents in facility activities for 1 of 5 residents reviewed (Resident 10). The facility census was 38. Findings are: Record review of the facility policy titled Activities dated 2/4/25 revealed that it is the facility policy to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility sponsored group, individual, and independent activities will be designed to meet the interests of each resident. Activities will encourage both independence and interaction within the community. Activities refers to any endeavor, other than routine ADLs (Activities of Daily Living- basic everyday tasks including bathing, eating, dressing, getting in and out of bed, and toileting), in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to, activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence. Each resident's interests and needs will be assessed on a routine basis. Activities will be designed with the intent to enhance the resident's sense of well-being, belonging, and usefulness. The facility's activities will create opportunities for each resident to have a meaningful life and reflect the resident's interests and age. Residents are encouraged, but not mandated, to participate in scheduled activities. Special considerations will be made for developing meaningful activities for residents with dementia and/or special needs. All staff will assist residents to and from activities when necessary. Record review of the Admission Record for Resident 10 dated 4/14/25 revealed that Resident 10 admitted into the facility on [DATE]. There were diagnoses listed of blindness in both eyes, depression, and diabetes. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 3/19/25 for Resident 10 revealed that Resident 10 felt down, depressed, or hopeless over half of the days of the assessment look-back period. The MDS revealed that Resident 10 felt lonely or isolated often. Resident 10 required substantial assistance from staff with standing from a sitting position, chair to bed transfer, and lying to sitting on the side of the bed. Resident 10 was dependent on staff for mobility. Active diagnoses included depression and blindness. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the Care Plan (an individualized written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 4/14/25 for Resident 10 revealed that Resident 10 will be encouraged to be involved in daily decision making to their maximum capacity. The care plan revealed that Resident 10 is blind and staff are to explain procedures to the resident. Resident 10 is dependent for transfers and wheelchair mobility. Resident 10 is at risk for psychosocial well-being. Interventions included observe for resident feelings that include isolation and unhappiness causative factors, provide assistance to reduce or eliminate causative and contributing factors, and provide opportunities for Resident 10 to participate in care. The care plan revealed a focus for the resident's diagnosis of depression. Interventions included assisting Resident 10 in developing and providing the resident with a program of activities that is meaningful and of interest and to encourage and provide opportunities for exercise and physical activity. Record review of the Activity Participation Review dated 10/29/24 for Resident 10 revealed that Resident 10 liked 1:1 activities in the resident's room. The section titled Describe resident's favorite activities, special accomplishments, and/or new interests revealed that Resident 10 just liked to listen to people talk. Record review of the Activity Participation Review dated 3/6/25 for Resident 10 revealed that Resident 10 benefits from 1:1 activities in their room. The section titled Describe resident's favorite activities, special accomplishments, and/or new interests revealed that Resident 10 enjoyed talking and loved to tell stories about growing up or about their late spouse. Record review of the Multidisciplinary Care Plan assessment dated [DATE] for Resident 10 revealed that Activities staff were present at the care plan. The section titled Activity Summary revealed no needs or concerns at that time. The goal listed was for Resident 10 to attend one activity outside of the resident's room. The resident and family were unable to attend the care plan. Interview on 4/14/25 at 11:37 AM with a family member of Resident 10 revealed that they would like Resident 10 to be invited to activities such as TV trivia. The family member revealed that they had told the facility about this. Observation on 4/14/25 at 3:51 PM in the room of Resident 10 revealed that Resident 10 was lying in bed. A radio in the room was playing music. Observation on 4/15/25 at 8:44 AM in the room of Resident 10 revealed that Resident 10 was lying in bed. No lights in the room were on. The room was silent. No radio or other form of entertainment was on in the resident room. Interview on 4/15/25 at 8:44 AM with Resident 10 revealed that the resident was unaware of where staff were at. Resident 10 revealed that no staff had come to assist the resident or bring their breakfast. Observation on 4/15/25 at 10:06 AM outside the facility dining room revealed a large April Activities calendar posting on the wall. The calendar revealed that the activities scheduled for 4/15/25 included TV Trivia at 10:30 AM. Observation on 4/15/25 at 10:11 AM in the hallway outside the facility dining room revealed that an overhead page announced that TV Trivia would begin in the tv room at 10:30 AM. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview 04/15/25 at 10:35 AM with the facility Activity Director (AD) revealed that TV trivia was a time filler and would be in the tv room if more residents showed up. Observation on 4/15/25 at 10:38 AM on the 400 hallway revealed that the facility AD walked through the 400 hall past the room of Resident 10. The AD did not enter the room of Resident 10. The AD continued through the 400 hall to the facility dining room without inviting any residents on the 400 hall to the TV trivia activity. Interview on 4/15/25 at 10:38 AM with the AD revealed that the AD did not invite Resident 10 to group activities since the resident was blind. The AD revealed that in-room [ROOM NUMBER]:1 activities were provided such as reading books to Resident 10. Observation on 4/15/25 at 10:42 AM outside the tv room revealed that the AD exited the 200 hall with Resident 14 and directed Resident 14 into the TV room. Observation on 4/15/25 at 10:43 AM in the TV room revealed the AD in the TV room starting the question/trivia on the tv. Three residents were present for the activity (including Resident 14). Resident 10 was not in attendance. Observation on 4/15/25 at 10:49 AM in the room of Resident 10 revealed that Resident 10 was lying on the bed. The resident room was dark with no lights on. No music or other entertainment was playing. Observation on 4/15/25 at 1:05 PM in the room of Resident 10 revealed Resident 10 seated in the recliner in the room with their feet up. The room was dark with no lights on. No music or other entertainment was playing. Observation on 4/15/25 at 2:32 PM in the room of Resident 10 revealed that Resident 10 sat in the recliner. The room was dark with no lights on. No radio, tv, or other entertainment was on. The overhead page announced that the movie Titanic and popcorn would start at 2:30 PM for residents. Observation on 4/15/25 at 2:47 PM in the tv room revealed that 2 residents sat in the tv room eating popcorn and watching the movie on the tv. Resident 10 was not in attendance. Observation 4/16/25 at 7:50 AM in the room of Resident 10 revealed that Resident 10 was lying in bed. The lights in the room were off and the room was dark. No radio or other entertainment was on. Observation on 4/16/25 at 9:05 AM in the room of Resident 10 revealed that Resident 10 remained in bed in the dark room. The room was silent with no radio or other entertainment. Observation on 4/16/25 at 9:32 AM in the room of Resident 10 revealed that the room door was closed. This surveyor knocked and entered. Resident 10 was lying in bed. The room was dark with no lights on. No radio or other entertainment was on. Observation on 4/16/25 at 9:52 AM revealed that Medication Aide-I (MA-I) entered the room of Resident 10 and checked Resident 10's blood pressure. The aide did not turn on the lights, radio, or offer any entertainment to Resident 10. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 4/16/25 at 9:57 AM with MA-I revealed that Resident 10's mood can change daily and that MA-I does not invite Resident 10 to facility activities. MA-I was unaware of any 1:1 activities for Resident 10. Observation on 4/16/25 at 11:10 AM in the room of Resident 10 revealed that Resident 10 was lying in bed and the lights in the room were off. No radio or other entertainment was on. Interview on 4/16/25 at 2:02 PM with the AD confirmed that the only documentation related to activity participation for Resident 10 was the documentation in the care plan progress note that Resident 10 prefered 1:1 activities. The AD confirmed that the AD had no documentation of individual 1:1 activities provided to Resident 10. The AD revealed that nurse aides document the resident participation in activities. Record review of the medical record for Resident 10 revealed no evidence of 1:1 activities being provided to Resident 10. The medical record revealed no evidence of resident participation in activities. Interview on 4/16/25 at 2:10 PM with Nurse Aide (NA)-L revealed that Resident 10 does ask for staff to turn the radio on when the resident wants it on. NA-L was unaware of any 1:1 activities for Resident 10. Interview on 4/16/25 at 2:13 PM with Resident 10 revealed that Resident 10 would like to attend activities that might be of interest. Resident 10 confirmed that staff do not ask the resident to attend activities. Resident 10 revealed that they would like to be invited to activities. Observation on 4/16/25 at 2:22 PM outside the facility dining room revealed that the AD announced over the overhead paging system that the Banana Splits activity would be in the dining room at 2:30 PM for residents. Observation on 4/16/25 from 2:22 PM through 2:45 PM on the facility 400 hall revealed that no staff went to the room of Resident 10 to invite Resident 10 to the activity. Observation on 4/16/25 at 2:50 PM revealed facility residents in the dining room for the banana splits. Resident 10 was not in attendance. Observation on 4/16/25 at 2:50 PM in the room of Resident 10 revealed that Resident 10 was lying in bed. The room was dark with no lights on. No radio or other entertainment was on in the room. Interview on 4/16/25 at 5:20 PM with the Regional Director of Operations (RDO) confirmed that Resident 10 should be asked to attend activities and that the facility should have documentation of any 1:1 activities provided to the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 49382 Licensure Reference Number 175 NAC 12-006.09(H)(iii)(2) Based on observation record review and interview, the facility failed to follow physician's orders to promote healing of a pressure related skin injury for 1 (Resident 29) of 1 sampled resident. The facility census was 38. Findings Are: A record review of a facility policy titled Wound Treatment Management dated 11/28/2023 revealed to promote wound healing it is the policy of the facility to provide treatments in accordance with physician orders and current standards of practice. A record review of an Admission Record revealed the facility admitted Resident 29 on 04/19/2024 with diagnoses of dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia, and the inability to plan and initiate complex behavior) and Type 2 Diabetes Mellitus (a common form of diabetes mellitus that develops especially in adults and most often in obese individuals and that is characterized by hyperglycemia resulting from impaired insulin utilization coupled with the body's inability to compensate with increased insulin production). A record review of Resident 29's Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 01/28/2025 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 5/15 indicating the resident was severely cognitively impaired. The resident was dependent on substantial or maximum assistance with eating transfers, bed mobility and transfers. The resident was coded to have one pressure related skin injury on the MDS. The resident was also coded to receive Hospice care. A record review of Resident 29 Electronic Medical Health Record (EMR) revealed physician orders to wash the right buttock wound with soap and water or wound wash then to apply gauze soaked in Dakins (Sodium Hypochlorite) Solution for 5 minutes. In an observation completed on 04/15/2025 at 3:50 PM of wound care being provided to Resident 29 by Registered Nurse (RN)-D the following was observed: -RN-D soaked a white 4 by 4 inch piece of gauze with a clear liquid from a bottle labeled with the resident name and Sodium Hypochlorite (a broad-spectrum antimicrobial solution used for disinfection of a wound). The RN then assisted the resident to roll onto their left side. The RN pulled down the residents' white incontinence product and removed a tan bordered foam dressing from the residents' right upper buttock. The RN then placed the soaked piece of gauze over the wound and had the resident roll back onto their back. The RN stated that the gauze had to stay in place over the wound for 5 minutes. The RN did not cleanse the wound prior to placing the soaked gauze over the wound. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview completed on 04/15/2025 at 4:10 PM with RN-D, RN-D confirmed that they should have cleansed the wound as ordered by the physician prior to applying the soaked gauze. In an interview completed on 04/15/2024 at 5:00 PM with the facility Director of Nursing (DON) the DON confirmed that the RN did not follow the physician orders when completing the treatment for Resident 29.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 50253 Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, record review and interview; the facility failed to ensure a medication error rate of less than 5%. Observations of 27 medications administered revealed 13 errors for 3 (Residents 194, 13, and 17) of 3 sampled residents, resulting in an error rate of 48.15%. The facility census was 38. Findings are: Record review of the policy Medication Errors dated 08/01/2023 revealed the purpose of the policy is to provide protections for the health, welfare, and rights of each resident ensuring residents receive care and services safely in an environment free of significant medications errors. Under the subheading Policy Explanation and Compliance stated the facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events. Paragraph 4 states that medication errors include errors in administration times. Paragraph 7 stated to prevent medication errors and ensure safe medication administration, nurses should verify the following; (a) right medication, dose route, and time of administration. Record Review of the policy Medication Administration dated 04/2025, revealed the policy is to ensure that medications are administered by individuals legally authorized to do so in the state as ordered by the physician and in accordance with professional standards of practice. Furthermore, the policy states under the subheading Policy Explanation and Compliance Guidelines sentence 10 that individuals must ensure that the six rights of medication administration are followed including (e) the right time. A. Record review of Resident 17's Electronic Medication Administration Record (EMAR) revealed an order for Levothyroxine 112 micrograms (mcg) to be given 30 minutes prior to meals in the morning, Omeprazole 40 milligrams (mg) to be given each morning one hour before meals, and cariprazone 1.5 mg daily. Observation on 04/14/2025 at 8:57 AM revealed Medication Aide (MA)-C prepared and administered medications for Resident 17 that included Levothyroxine (a thyroid mediation) 112 mcg and Omeprazole (reduces stomach acid) 40 mg while the resident was seated in the dining room eating breakfast. Medications were given whole and mixed with pudding prior to administration. Cariprazine (for schizophrenia) was not available. Interview on 04/14/2025 at 10:00 AM with MA-C confirmed the levothyroxine and the omeprazole were given while Resident 17 was eating breakfast. MA-C further confirmed that the cariprazine was not available and had not been given. The pharmacy had been contacted on 4/13/2025 and MA-C sent another note to the pharmacy 4/14/2025 to request the medication. MA-C then informed the charge nurse that there was still no cariprazine for the resident. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Record review of the EMAR for Resident 194 revealed that all of the medications for Resident 194 were red, which indicated they were overdue. The medications included orders for Eliquis (a blood thinner) 5 mg twice daily, lasix (a diuretic) 80 mg daily, atorvastatin (for high cholesterol) 10 mg daily, and citalopram (antidepressant) 20 mg daily were all due at 8:00 AM. The allopurinol (for gout) 200 mg daily, enalapril 5 mg daily, and metoprolol 100 mg twice daily were due at 9:00 AM. Observation on 04/14/2025 at 9:40 AM revealed MA-C prepared and administered Eliquis, Lasix, allopurinol, atorvastatin, citalopram, enalapril, and metoprolol for Resident 194. Interview on 04/14/2025 at 10:00 AM with MA-C confirmed that all of the medications that were ordered to be given to Resident 194 at 8:00 AM were administered late. C. Record review of Resident 13's EMAR revealed orders for Senna/Docusate (a laxative) 8.6 mg/50 mg 2 tablets every 12 hours, amiodarone (for irregular heartbeat) 200 mg daily, aspirin 81 mg daily, carvedilol (for high blood pressure) 3.125 mg twice daily with food, clopidogrel (a blood thinner) 75 mg daily, spironolactone (a diuretic) 25 mg one half tablet daily, and Flomax 0.8 mg daily. Observation on 04/14/2025 at 11:28 AM as MA-C prepared and administered medications for Resident 13 which were all ordered to be given at 8:00 AM. The resident had eaten very little of the breakfast served at 8:00 AM and was lying in bed at the time of administration. Interview on 4/14/2025 at 11:30 AM with MA-C who confirmed that all of the medications were administered late. MA-C also confirmed that the carvedilol was supposed to be given with food, and the resident had not eaten nor had any type of snack been given to the resident at the time of the medication administration.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49382 Licensure Reference Number 175 NAC 12-006.11(E) Based on observation, interview, and record review; the facility failed to ensure that the facility dishwasher was operating, ensuring facility dishes and utensils were sanitized when washed with the facility dishwasher which had the potential to affect all residents utilizing dishware from the kitchen. The facility also failed to ensure that staff handled foods and assisted residents with meals in a sanitary manner to prevent the potential for cross contamination and foodborne illness. This affected 3 of 20 residents observed (Residents 1, 192, and 11). The facility census was 38. Findings are: A. A record review of an undated facility policy titled Dishwashing: Machine Operation Guideline and Procedure Manual revealed wash temperature must reach a minimum of 120 degrees. If temperatures are not accurate, stop using the dish machine immediately. In an observation on 04/13/2025 at 6:10 PM, it was observed that the facility dishwashing machine temperature during the wash cycle was 98 degrees. In an interview completed on 04/13/2025 at 6:20 PM with the Facility Administrator (FA) the FA confirmed that the facility dishwashing machine was reaching the minimum temperature of 120 degrees. FA stated dietary staff would use the 3-sink sanitization system and they would contact someone to come and examine and fix the dishwasher. In an observation on 04/14/2025 at 7:45 AM, it was observed that the facility dishwashing machine was in operation/being utilized to wash dishes. The temperature during the wash cycle was observed to be 100 degrees. In an interview on 04/14/2025 at 7:45 AM with Cook-B, Cook-B confirmed that they were using the dishwashing machine for the cleaning and sanitization of dishes. The [NAME] also confirmed that the dishwashing machine temperature was not reaching 120 degrees as specified by policy. In an interview completed on 04/14/2025 at 8:15 AM with the FA, the FA confirmed that the dishwasher should not be being used due to not achieving the 120 degrees as specified by policy. 41938 B. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Record review of the facility policy titled Food Safety Requirements dated 3/26/25 revealed that it is the policy of the facility to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Foods and beverages shall be distributed and served to residents in a manner to prevent contamination. Strategies include: washing hands between contact with residents and use of gloves when touching and assisting with ready-to-eat foods. Staff shall adhere to safe hygienic practices (food safety processes used to prevent the spread of germs and illnesses) to prevent contamination of foods from hands or physical objects. Staff shall wash hands according to facility procedures. Staff shall not touch food with bare hands-use gloves, tongs, deli paper, or spatula. Observation on 4/13/25 at 6:27 PM in the facility dining room revealed that Nurse Aide (NA)-A picked up a piece of cookie from the plate of Resident 1 with their bare hand and fed it to Resident 1. NA-A did not perform hand sanitization (hand washing using soap and water or an alcohol-based hand rub (ABHR) to remove germs for reducing the risk of transmitting infection among patients and health care personnel). NA-A went to another table and picked up the fork from Resident 192. NA-A fed a bite of food to Resident 192 using the fork. NA-A sat next to Resident 192 and rubbed the top of the tire of the resident's wheelchair wheel with their bare right hand as NA-A visited with Resident 192. NA-A handed the fork to Resident 192. Resident 192 used the fork to take a few bites of food. NA-A did not perform hand sanitization. NA-A returned to the table of Resident 1. NA-A picked up a piece of cookie from the plate in front of Resident 1 with the bare right hand and fed the piece of cookie to Resident 1. NA-A did not perform hand sanitization. Resident 11 sat across the table from Resident 1. Resident 11 tried to use a fork to eat the meat on their plate. Resident 11 was unable to cut up the meat. NA-A did not perform hand sanitization. NA-A went to Resident 11 and picked up the fork. NA-A used the fork to cut up the meat on the plate for Resident 11. NA-A explained to Resident 11 where the foods were located on the plate. Resident 11 used the fork to take a bite of food. NA-A did not perform hand sanitization. NA-A returned to Resident 1 and used the bare hands to adjust the clothing protector on Resident 1. NA-A did not perform hand sanitization. NA-A went to Resident 192 and rubbed the resident's shoulder with the bare left hand. NA-A did not perform hand sanitization. NA-A went to Resident 11 and used their bare left hand and picked up the right hand of Resident 11 and removed the fork from Resident 11's hand. NA-A picked up a spoon from the table in front of Resident 11 with their bare hands and placed the spoon in the right hand of Resident 11. NA-A did not perform hand sanitization. NA-A went to the table of Resident 192 and picked up the spoon from the plate of Resident 192 with their bare hand. NA-A fed a spoonful of meat to Resident 192. The time was now 6:30 PM. Resident 8 walked with a walker to the table of Resident 1. NA-A did not perform hand sanitization. NA-A used the bare hands to tuck the front of Resident 8's shirt into their pants and tied the waist string of the pants for Resident 8. NA-A went to the alcohol based hand sanitizer dispenser on the wall and applied sanitizer and rubbed the hands together. NA-A went to Resident 1 and picked up a piece of cookie from the plate in front of Resident 1 with the bare hand and fed it to Resident 1. NA-A picked up another piece of the cookie from the plate in front of Resident 1 with the left bare hand and fed the piece of cookie to Resident 1. NA-A told Resident 1 that was all of the cookie and offered to check and see if the kitchen had any more cookies if the resident wanted more. Resident 1 responded yes that they would like another cookie. NA-A went to the kitchen service window, obtained a plate with a chocolate chip cookie, and carried the plate with the cookie to the table of Resident 1. NA-A sat the plate on the table in front of Resident 1. NA-A picked up the cookie with their bare hands and began to break the cookie into small pieces. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 4/16/25 at 11:25 AM with the Regional Director of Operations (RDO) confirmed that staff assisting residents with meals are expected to perform hand sanitization between residents and after contact with resident items. The RDO confirmed that gloves are to be worn when touching ready to eat foods and not handle foods with the bare hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285144	A. Building B. Wing	04/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pines at Blue Hill	414 North Willson Street Blue Hill, NE 68930

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 49382 Licensure Reference Number 175 NAC 12-006.07 Based on interview and record review the facility failed to implement Quality Assurance and Performance Improvement (QAPI) processes for identified concerns with ongoing evaluation. This had the potential to affect all of the residents residing in the facility. Facility census was 38. Findings are: A record review of a facility policy titled Quality Assurance and Performance Improvement (QAPI) dated 2024 revealed the facility is to develop, implement, and maintain an effective, comprehensive, QAPI program. The facility will draw data from multiple sources including grievance logs. The data is used to develop and monitor performance indicators. The QAPI process key components include tracking and measuring performance, establishing goals, identifying and prioritizing deficiencies, systematic analyzation of underlying causes, and developing and implementing corrective action or performance improvement activities. In an interview on 04/16/2025 at 1:30 PM with the Facility Administrator (FA), the FA stated that they were the QAPI Committee Coordinator. The FA stated one source of information for process improvements were resident grievances. The FA confirmed that resident grievances for the prior month were reviewed during the meeting including interventions for resolution of the grievance and outcome. A record review of an undated facility-supplied document titled QAA Committee Meeting Agenda, under section 9 Quality of Life Review, grievances was a listed topic. A record review of a facility supplied document titled Resident Greivance Log and dated 12/2024 revealed 3 grievances were filed by residents, all involving personal cares. A record review of a facility supplied document titled QAPI Meeting dated January 2025 under the Social Services section labeled Grievances, 1 grievance was listed for the month of December 2024. A record review of a facility supplied document titled Resident Greivance Log and dated 02/2025 revealed 2 grievances were filed by residents involving bathing and resident appearance. A record review of a facility supplied document titled QAPI Meeting Dated March 2025 under the Social Services section labeled Grievances, no grievances were listed for the month of February 2025. In an interview completed on 04/16/2025 at 1:45 PM the FA stated the facility currently had no process improvement plans active. The FA confirmed that resident grievances were a source for information and process improvements. The FA confirmed that the grievances filed by residents in December 2024 and February 2025 were not reviewed during the QAPI meeting and process improvement plans were not developed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50253 Based on record review, interview, and observation; the facility failed to ensure that hand hygiene was performed between residents during medication administration to 3 (Residents 17, 31, and 26) of 3 sampled residents and during wound care for 1 (Resident 29) of 1 sampled resident to prevent the potential for cross contamination and infection. The facility census was 38. Findings are: Record review of CDC Guideline for Hand Hygiene in Health Care Settings dated 2007 revealed the use of alcohol-based hand rub or washing with soap and water should be done between patients when performing cares. A. Observation on 4/14/2025 at 9:00 AM of Medication Aide (MA) C while passing medications in the dining room. MA-C did not perform hand hygiene as required between Residents 17, 31, and 26 while preparing and administering medications. Interview on 4/14/2025 at 9:20 AM with MA-C confirmed the MA did not perform hand hygiene as required during medication preparation and administration between Residents 17, 31, and 26. 49382 B. A review of a facility policy titled Wound Treatment Management dated 11/28/2023 revealed that to promote wound healing the facility will provide treatments in accordance with current standards of practice and physician orders. A review of CDC Guideline for Hand Hygiene in Health Care Settings dated 2007 revealed the use of alcohol-based hand rub or washing with soap and water should be done following the removal of gloves. In an observation completed on 04/15/2025 at 3:50 PM of wound care being provided by Registered Nurse (RN)-D the following was observed: -RN-D donned gloves to both hands and applied a moist piece of gauze to Resident 29's upper right buttock. The RN then removed their gloves and donned another pair of gloves. The RN then proceeded to apply another piece of moist gauze to the resident's left heel and hold that gauze in place with their gloved hand. The RN did not perform hand hygiene between glove changes. -RN-D removed their gloves after holding the moist gauze in place to the resident's heel. The RN then donned new gloves to both hands and obtained a pair of scissors and clean dressing from the bed side table. The RN did not perform hand hygiene between glove changes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-RN-D applied a new clean dressing to the resident's right upper buttock wound with gloved hands. The RN removed the gloves from their hands and donned another pair of gloves on both hands. The RN then obtained a package labeled Kerlex and opened the package with their gloved hands. The RN did not perform hand hygiene between glove changes. In an interview completed on 04/15/2025 at 4:15 PM with RN-D, RN-D confirmed that they did not perform hand hygiene between glove changes during the wound care. The RN stated hand hygiene should have been performed between each glove change by washing hands with soap and water or using alcohol-based hand rub. In an interview completed on 04/15/2025 with the facility Director of Nursing (DON), the DON confirmed that hand hygiene should be performed between glove changes by washing hands with soap and water or using alcohol-based hand rub.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have enough outside ventilation via a window or mechanical ventilation, or both. 41938 Licensure Reference Number 175 NAC 12-007.04(D) Based on observation, record review, and interview the facility failed to ensure that bathroom exhaust vent fans were functioning for 2 of 16 residents observed (Residents 34 and 10). The facility census was 38. Findings are: Record review of the facility's undated Admission Agreement Attachment 3 titled Resident Rights revealed that the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. The resident has the right to a safe, clean, comfortable, and homelike environment. The facility must provide a safe, clean, comfortable, and homelike environment. The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. A. Observation on 4/14/25 at 8:00 AM in the bathroom of Resident 10 revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. Observation on 4/16/25 at 12:48 PM in the room of Resident 10 with the Facility Administrator (FA) confirmed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. The FA confirmed that the bathroom exhaust vent was not functioning and needed repair. B. Observation on 4/14/25 at 8:04 AM in the bathroom of Resident 34 revealed that the bathroom exhaust vent would not pull up a 1-ply square of toilet paper. Observation on 4/16/25 at 12:46 PM in the room of Resident 34 with the FA confirmed that the bathroom exhaust vent would not pull a 1-ply square of toilet paper. The FA confirmed that the bathroom exhaust vent was not functioning and needed repair. Interview on 4/16/25 at 12:53 PM with the FA confirmed that the facility currently did not have a maintenance director. The FA confirmed that the bathroom exhaust vents are required to be maintained and kept functional.