| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285147 | A. Building<br>B. Wing | 08/01/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Oaks at Central City | 2720 South 17th Avenue<br>Central City, NE 68826 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48271<br><br>Based on record review and interviews; the facility failed to ensure a PASRR (Pre-admission Screening and Resident Review) for individuals with a mental disorder or intellectual disability were accurately completed to determine if a level II PASARR review was warranted for 1 (Resident 39) out of 20 sampled residents. The facility census was 60.<br><br>Findings are:<br><br>A record review of Admission Record with the printed date of 7/30/24 revealed Resident 39 was admitted on [DATE], and a re-admitted [DATE] with the diagnoses of Schizoaffective Disorder( a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions), Major depressive Disorder (A mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life),post-traumatic stress Disorder,)a mental health condition that's triggered by a terrifying event-either experiencing it or witnessing it).<br><br>A record review of the History and Physical from the Hospital dated 6/7/22 revealed a past medical history of schizoaffective disorder, PSTD, mood disorder, and depression.<br><br>A record review of the MDS (Minimum Data Set, a comprehensive assessment of each residents' functional capabilities) dated 5/1/24 revealed in section I active diagnoses of depression, schizophrenia and Post-traumatic stress Disorder was marked with an X indicating yes.<br><br>A record review of the PASRR dated 3/30/21 revealed in the section Behavioral Health Diagnosis: According to the PASRR 1 level screening this individual has a diagnosis of or a suspicious of Major Depressive Disorder and substance abuse.<br><br>A record review of the PASRR dated 6/8/22 revealed that in the section Behavioral Health Diagnosis: According to the PASRR level 1 screening this individual has a diagnosis of or suspicious of the following. There is no diagnosis listed.<br><br>An interview on 7/30/24 10:30 AM with DON (Director of nursing) confirmed that the diagnoses of schizoaffective disorder and post-traumatic stress disorder was not on the PASRR and schizoaffective disorder and post-traumatic stress disorder should have been on the PASRR<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 7/30/24 10:31 AM with Administrator confirmed that the diagnoses of PSTD and Schizoaffective disorder should have been on the PASRR and wasn't. The Administrator further revealed the PASRR was done at the hospital, and they did the PASRR incorrectly, but the Social Worker should have caught it.<br><br>An interview on 7/31/24 9:14 AM with SSD (Social Service Director) confirmed that the diagnoses of schizoaffective disorder and Post Traumatic Stress Disorder was not on the PASRR and it should of been on the PASRR. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48271<br><br>Licensure Reference Number 175 NAC 12-006.09<br><br>Based on record review, observations, and interviews; the facility failed to follow up and complete Physician's orders regarding Auto-PAP (Continuous positive airway pressure) for 1 (Resident 34) of 20 sampled residents. The facility census was 60.<br><br>A record review of the Admission Record revealed that Resident 34 was admitted to the facility on [DATE] with diagnosis of: Obstructive Sleep Apnea(characterized by episodes of a complete airway collapse or a partial collapse with an associated decrease in oxygen saturation or arousal from sleep).<br><br>An interview on 7/29/24 at 1:30 PM with Resident 34 confirmed that [gender] does not use the Auto-Pap machine because the mask is too tight on [gender] face. Resident 34 revealed that [gender] had informed the staff regarding the mask being too tight.<br><br>An interview on 7/30/24 at 9:30 AM with Resident 34 revealed that [gender] did not wear the Auto-Pap last night.<br><br>A record review of the hospital referral packet from Hospital dated 10/1/23 revealed patient active problem list state: Obstructive sleep Apnea on C-Pap since 11/20/18.<br><br>A Record review of the Medical Clinic Nursing Home Visit form with a printed date of 10/18/23 revealed on the top of the form CC: how am I supposed to breath at night without my CPAP?, Resident 34 inquiring about a new CPAP. There are no orders addressing Resident 34 concerns regarding the CPAP.<br><br>A record review of Physician orders dated 4/11/24 revealed an order for Auto-Pap.<br><br>A record review of Medication Administration orders revealed an Auto-Pap with a start date of 5/3/24.<br><br>A record review of Medication Administration orders revealed that starting on May 3 Resident 34 wore [gender] Auto-pap 17 times and refused to wear the Auto-pap 11 times.<br><br>A Record review of Medication Administration orders revealed that in the month of June Resident 34 wore the Auto-Pap 9 days and refused to wear the Auto -Pap for 21 days.<br><br>A Record review of Medication Administration orders revealed that in the month of July Resident 34 wore the Auto-Pap 4 times and refused to wear the Auto-Pap for 26 times.<br><br>A Record review of the Progress Note dated 7/1/24 revealed that the facility placed a call to Midwest Respiratory to inquire about possible titration or other recommendations for Resident 34's Auto-Pap, the respiratory therapist will return call. There was no other follow up notes regarding Midwest.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview on 7/30/24 at 11:30 AM with RN-A (Registered Nurse-A) revealed that [gender] was aware Resident 34 refuses the Auto-Pap, and was unaware if the Doctor had been notified.<br><br>An interview on 7/30/24 at 2:00 PM with DON (Director of Nursing) and Administrator confirmed that they had contacted Midwest and their corporate nurse regarding Midwest stating they couldn't help. The administrator confirmed that the resident had a beard and thought that was making the mask feel tight.<br><br>The DON confirmed that Resident 34's orders for the auto-pap should have been ordered on admission and follow up should have been done with the physician and respiratory therapist. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49164<br><br>Licensure Reference Number 175 NAC 12-006.18 (B) & (D)<br><br>Based observations, interviews, and record review; the facility failed to secure a catheter to prevent cross contamination during catheter cares for 1 (Residnet 53), and failed to change gloves and perform hand hygiene when performing peri care and wound care for 3 (Resident 53, 26, and 8) of 3 sampled residents. The facility census was 60.<br><br>The Findings are:<br><br>Record Review of Resident 53's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 4/28/24 revealed Resident 53 admitted to the facility on [DATE] with diagnoses of: Dementia ( Dementia is a general term for loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life)with behavioral disturbance, neurogenic bladder (is a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition.), intellectual disabilities, and hypothyroidism (the thyroid gland doesn't make enough thyroid hormones to meet the body's needs). The MDS indicated Resident 53 had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid), and was dependent on staff assistance for eating, dressing, bed mobility, bathing, and personal hygiene.<br><br>An observation on 7/30/24 at 7:57 AM revealed Registered Nurse (RN) D changing Resident 53's catheter bag. RN D entered the room with a new catheter drainage bag and several individually wrapped alcohol wipes. After performing hand hygiene and donning gloves, RN D located the connection between the urinary catheter and the drainage tubing, by rolling down Resident 53's pants. Then RN D opened the new catheter drainage bag and tubing, and the new bag and tubing fell to the floor. RN D picked up the catheter bag and proceeded to disconnect the old tubing from the catheter. While doing this the new catheter bag and tubing fell to the floor again and RN D holding the urinary catheter in the left hand used the right hand to pick up the catheter bag and tubing off the floor. Once RN D disconnected the old catheter tubing, [gender] used an alcohol wipe and scrubbed the end of the old catheter, and used another alcohol wipe to scrub the end of the new tubing and then connected the new tubing to the catheter.<br><br>An interview was conducted with RN D on 7/30/24 at 9:34 AM confirmed that the catheter drainage bag and tubing fell to the floor while changing the catheter drainage bag.<br><br>An interview with the Infection Control Preventionist (ICP) on 8/1/24 at 10:37 AM confirmed the catheter bag touching the floor had the potential to cause cross contamination.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An observation on 7/31/24 at 7:00 AM revealed Medication Aide (MA) C performing urinary catheter care and pericare (the cleaning of the private areas of a patient) for Resident 53. Resident 53 was lying in bed, MA C performed hand hygiene and donned gloves then removed the covers from Resident 53. MA C using disposable wipes wiped Resident 53's right groin, then folded wipe and wiped the left groin and discarded the wipe in the trash. Then MA using a clean wipe wiped down the center of the peri area and discarded the wipe. Then MA C took a new wipe and wiped around the catheter insertion site and down the tubing away from the resident. Resident 53 was rolled to the left side and MA C using a new wipe, wiped the right buttock, folded and wiped the left buttock, folded and wiped the gluteal cleft. With the same soiled gloved hands applied a clean brief, support stockings, shirt and pants.<br><br>An interview on 7/31/2024 at 7:22 AM with MA C confirmed [gender]did not change gloves and perform hand hygiene, after performing pericare for Resident 53.<br><br>An interview with the ICP on 8/01/2024 at 10:40 AM confirmed that soiled gloves should be removed and hand hygiene performed after pericare and before applying clean clothes.<br><br>Record Review of the facility Hand Hygiene policy dated 4/01/24 revealed all staff will perform hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Included in the policy is a Hand Hygiene Table which indicated during resident care hand hygiene should be performed when moving from a contaminated body site to a clean body site.<br><br>47406<br><br>B.<br><br>Record review of Resident 26's Admission Record revealed Resident 26 admitted to the facility on [DATE].<br><br>An observation on 7/30/24 at 10:44 AM with RN-A for Resident 26's wound care. RN-A performed hand hygiene with hand sanitizer and donned (put on) gloves and gown. The resident then stood up and turned around facing the recliner during wound care. RN-A pulled the slacks and pullup down. Without changeing gloves RN-A cleansed the wound with wound cleanser and gauze. RN-A then changed gloves without performing hand hygiene in between the glove change. RN-A then administered zinc paste to Resident 26's wound. Next RN-A pulled Resident 26's pullup and slacks up. RN-A doffed (took off) gloves, placed in the trash, then took trash to the shower room down the hallway where [gender] placed in the trash bin. RN-A then washed hands with soap and water for 20 seconds.<br><br>An interview on 7/30/24 at 10:58 AM with RN-A revealed [gender] should have washed [gender] hands after removing dirty gloves, between glove changes, and before leaving residents' room.<br><br>An interview on 7/31/24 at 1:06 PM with the DON revealed the expectation was for the nurse to do hand hygiene after removing dirty gloves and before donning gloves, and before leaving residents' room.<br><br>C.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident 8's Admission Record revealed Resident 8 admitted to the facility on [DATE].<br><br>An observation on 7/31/24 at 2:04 PM with Licensed Practical Nurse (LPN)-C performing wound cares on buttock and toe for Resident 8. LPN-C donned gloves and gown without performing hand hygiene prior. LPN-C pulled down the resident's pullups and slacks then cleansed the wound with gauze and wound cleanser. LPN-C then applied a new mepilex dressing using the same gloves. Next LPN-C pulled the pullups and slacks up for Resident 8. LPN-C doffed gloves and cleansed hands with hand sanitizer. LPN-C donned clean gloves and removed the sock from right foot. LPN-C using the same gloves cleansed the toe wound with gauze and wound cleanser and applied a new dressing. LPN-C then applied a clean sock. LPN-C removed the trash bag and took it to the shower/whirlpool room trash receptacle. LPN-C then washed [gender] hands with soap and water for 10 seconds.<br><br>Interview with LPN-C on 7/31/24 at 2:22 PM revealed that [gender] should have performed hand hygiene before donning gloves when [gender] first entered the room, after removing the sock, after cleansing buttock and toe wound. LPN-C further confirmed [gender] should have washed hands with soap and water for 20 seconds.<br><br>Interview on 7/31/24 at 2:24 PM with DON revealed that LPN-C should have done hand hygiene before donning gloves when [gender] first entered the room, after removing the sock, after cleansing toe wound. DON further revealed LPN-C should have washed [gender] hands with soap and water for 20 seconds.<br><br>Record review of Hand Hygiene Policy dated 4/1/24 revealed:<br><br>-All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility.<br><br>-Hand hygiene technique when using soap and water. Apply to hands the amount of soap recommended by the manufacturer. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse the hands with water.<br><br>-Additional considerations: The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. |