

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/04/2025
NAME OF PROVIDER OR SUPPLIER Wisner Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1105 9th Street Wisner, NE 68791	

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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>51391</p> <p>Licensure Reference Number 175 NAC 12-006.18</p> <p>Based on observations, interview and record review; the facility failed to implement enhanced barrier precautions for Resident 15. The sample size was 15 with a census of 33.</p> <p>A. Review of the facility policy Enhanced Barrier Precautions implemented on 5/17/24 revealed the following:</p> <ul style="list-style-type: none"> -Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of Multi-Drug-Resistant Organisms (MDRO) that utilizes gown and glove use during high contact resident care activities, -an order for EBP would be obtained for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO, or had an infection or colonization with a Centers for Disease Control (CDC)-targeted MDRO, -Personal Protective Equipment (PPE) for EBP was only necessary when performing high-contact care activities, -the infection preventionist would incorporate periodic monitoring and assessment of adherence to determine the need for additional training, -High-contact resident care activities included: dressing, transferring, providing hygiene, changing briefs or linens, toileting assistance, and wound care, and -EBP should be used for the duration of the affected residents stay in the facility or until resolution of what puts the resident at higher risk. <p>B. Review of Resident 15's weekly skin assessment notes from 12/23/24 to 2/24/25 revealed that the resident had a stage 3 pressure ulcer, identified stage 3 pressure ulcer on 12/23/24 to the right upper buttock/coccyx.</p> <p>The following observations were made related to Resident 15:</p> <ul style="list-style-type: none"> -on 2/26/25 at 9:10 AM there was no sign posted, or visible isolation supplies for EBP, <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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-on 2/27/25 at 9:15 AM there was no sign posted or visible isolation supplies for EBP</p> <p>-on 2/27/25 at 10:00 AM Nursing Assistant (NA)-E and NA-I entered Resident 15's room to complete toileting cares, staff did not put gowns on as required when entering the room, and</p> <p>-on 3/3/25 at 7:45 AM there was no sign posted or visible isolation supplies for EBP, RN-H completed skin assessment to wounds on Resident 15's buttock, staff did not put gowns on as required when entering the room.</p> <p>Interview with Registered Nurse (RN)-H, skin nurse on 3/3/25 at 8:15 AM confirmed that Resident 15's wounds to buttocks were chronic and that the the facility failed to implement EBP per policy.</p>		