STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285160	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph's Rehabilitation & Care Center	401 North 18th Street Norfolk, NE 68701

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 29638 Licensure Reference Number 175 NAC 12-006.04(F)(i)5 Based on interview and record review; the facility failed to notify the Primary Care Physician (PCP) when Resident 17 did not receive an ordered medication, a Continuous Positive Airway Pressure (CPAP- a medical treatment that uses a machine to deliver air pressure to keep breathing airways open while sleeping) machine was available and a treatment was provided as ordered. In addition, the PCP for Resident 22 was not notified of a failure to administer an ordered medication which led to a hospitalization . The sample size was 2 and the facility census was 44. Findings are: A. Review of the facility Resident's Rights Policy with a revision date of 8/2007 revealed it was the policy of the facility to promptly notify the resident, his/her attending physician, and/or family/responsible party of changes in the resident's condition and/or status. The policy indicated the Charge Nurse was to notify the resident's attending physician when: -the resident had a significant change in the resident's physical, mental, or psychosocial status. -there was a need to alter the resident's treatment significantly. -the resident repeatedly refused or did not receive treatment or medications for 3 or more consecutive times. -it was deemed necessary or appropriate in the best interest of the resident. B. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 17's Medication Administration Record (MAR) dated 10/2024 revealed an order dated 10/4/24 for Memantine (medication used to slow the progression of moderate to severe Alzheimer's disease) 28-10 milligrams (mg) daily. Further review of the MAR revealed from 10/4/24 to 10/7/24 and from 10/22/24 to 10/30/24 (13 out of the total 28 days) the resident was not provided the medication as the medication was not available. Review of Resident 17's Treatment Administration Record (TAR) dated 10/2024 revealed an order dated 10/4/24 for a CPAP machine to be used every night for obstructive sleep apnea. Further review of the TAR revealed from 10/4/24 to 10/8/24, 10/13/24, 10/15/24, 10/16/24, 10/19/24, 10/22/24, 10/25/24, 10/26/24, 10/28/24 and 10/29/24 (15 out of the total 28 days) the resident did not receive the CPAP machine as ordered. Review of the resident's TAR for 10/2024 revealed an order dated 10/13/24 at 4:12 PM to walk the resident 5 times a day due to weakness. The resident was to be assisted to walk at 8:00 AM, 11:00 AM, 2:00 PM, 5:00 PM and at 9:00 PM. Further review revealed no evidence Resident 17 was assisted with walking at: -8:00 AM on 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/23, 10/25, 10/28, 10/29, and 10/30 (11 out of 18 days). -11:00 AM on 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/23, 10/24, 10/25, 10/28, 10/29 and 10/30 (13 out of the 18 days). -2:00 PM on 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/23, 10/24, 10/25, 10/28, 10/29 and 10/30 (13 out of the 18 days). -5:00 PM on 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/23, 10/24, 10/25, 10/28, 10/29 and 10/30 (13 out of 19 days). -9:00 PM on 10/13, 10/15, 10/16, 10/17, 10/19, 10/21, 10/22, 10/26, 10/27, 10/28, 10/29, and 10/30 (12 out of 19 days). Review of the resident's electronic medical record revealed no evidence Resident 17's PCP was notified the resident did not receive the CPAP machine, the Memantine 28-10 mg daily, and was not ambulated by the staff 5 times a day as ordered by the physician. During an interview on 12/16/24 at 3:41 PM, the Director of Nursing (DON) confirmed the resident's PCP was never notified the resident was not provided the treatment and medications as ordered by the physician. C. Review of Resident 22's MAR dated 11/2024 revealed an order dated 11/15/24 for Prednisone 10 mg daily with food for 14 days related to respiratory failure. Further review of the MAR revealed the resident did not receive the Prednisone 10 mg daily from 11/26/24 to 11/30/24 (4 days). Review of the resident's MAR dated 12/2024 revealed the resident did not receive the Prednisone 10 mg daily on 12/1/24 and 12/2/24. (continued on next page)

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 22's Nursing Progress Notes revealed the following: -12/2/24 at 2:48 PM the resident was complaining of shortness of breath and lung sounds were diminished. -12/3/24 at 9:33 AM the resident's Prednisone 10 mg daily was not administered as it was not available. -12/3/24 at 4:59 PM the resident was sent to the emergency room (ER) for evaluation. The resident returned from the ER with a diagnosis of Bronchitis. -12/4/24 at 10:17 AM the resident's Prednisone 10 mg daily was not administered as it was not available. -12/5/24 at 2:08 PM the resident was complaining of shortness of breath with labored respirations and an oxygen saturation (amount of oxygen in the blood) level of 80 percent. Lung sounds were coarse and the resident's oxygen saturation levels dropped to 71 percent. The resident was set to the ER and was admitted to the hospital with a diagnosis of pneumonia. During an interview on 12/16/24 at 3:29 PM, the Director of Nursing confirmed the resident's physician was never notified the Prednisone 10 mg daily was not available and that the resident did not receive the medication as ordered.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number: 175 NAC 12-006.09 Based on interview and record review; the facility failed to follow practitioner's orders for Resident 17 related to administration of medications, use of a Continuous Positive Airway Pressure (CPAP- a medical treatment that uses a machine to deliver air pressure to keep breathing airways open while sleeping) machine and treatment orders and Resident 22 regarding medications. The sample size was 2 and the facility census was 44. Findings are: A. Review of Resident 17's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 10/9/24 revealed the resident was admitted [DATE] with diagnoses of high blood pressure, heart failure, Alzheimer's disease, non-Alzheimer's dementia, depression and obstructive sleep apnea (sleep disorder characterized by repeated episodes of partial or complete blockage of the upper airway during sleep). The following was assessed for the resident: -cognition was severely impaired. -required partial to moderate staff assistance with transfers and ambulation. -shortness of breath with exertion. -use of oxygen therapy. -use of non-invasive mechanical ventilator. Review of Resident 17's Medication Administration Record (MAR) dated 10/2024 revealed an order dated 10/4/24 for Memantine (medication used to slow the progression of moderate to severe Alzheimer's disease) 28-10 milligrams (mg) daily. Further review of the MAR revealed from 10/4/24 to 10/7/24 and from 10/22/24 to 10/30/24 (13 out of the total 28 days) the resident was not provided the medication as the medication was not available. Review of Resident 17's Treatment Administration Record (TAR) dated 10/2024 revealed an order dated 10/4/24 for a CPAP machine to be used every night for obstructive sleep apnea. Further review of the TAR revealed from 10/4/24 to 10/8/24, 10/13/24, 10/15/24, 10/16/24, 10/19/24, 10/22/24, 10/25/24, 10/26/24, 10/28/24 and 10/29/24 (15 out of the total 28 days) the resident did not receive the CPAP machine as ordered. Review of the resident's TAR for 10/2024 revealed an order dated 10/13/24 at 4:12 PM to walk the resident 5 times a day due to weakness. The resident was to be assisted to walk at 8:00 AM, 11:00 AM, 2:00 PM, 5:00 PM and at 9:00 PM. Further review revealed no evidence Resident 17 was assisted with walking at: (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-8:00 AM on 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/23, 10/25, 10/28, 10/29, and 10/30 (11 out of 18 days). -11:00 AM on 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/23, 10/24, 10/25, 10/28, 10/29 and 10/30 (13 out of the 18 days). -2:00 PM on 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/23, 10/24, 10/25, 10/28, 10/29 and 10/30 (13 out of the 18 days). -5:00 PM on 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/23, 10/24, 10/25, 10/28, 10/29 and 10/30 (13 out of 19 days). -9:00 PM on 10/13, 10/15, 10/16, 10/17, 10/19, 10/21, 10/22, 10/26, 10/27, 10/28, 10/29, and 10/30 (12 out of 19 days). During an interview on 12/16/24 at 3:41 PM, the Director of Nursing (DON) confirmed the following regarding Resident 17: -order dated 10/4/24 for Memantine 28-10 mg daily. However, due to issues with receiving the medication from the pharmacy, the resident was not administered the ordered medication on 13 out of a total of 28 days. -the resident was admitted with an order for a CPAP however, a CPAP machine was never available and so was never utilized. -confirmed the resident was to be ambulated 5 times a day to increase strength and was uncertain why the staff were not walking the resident. -the facility did not have a policy related to following physician orders. B. Review of Resident 22's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of heart failure, atrial fibrillation, high blood pressure renal insufficiency, pneumonia, diabetes, pulmonary edema, and respiratory failure. The resident was identified as having oxygen therapy. Review of the resident's MAR dated 11/2024 revealed an order dated 11/15/24 for Prednisone 10 mg daily with food for 14 days related to respiratory failure. Further review of the MAR revealed the resident did not receive the Prednisone 10 mg daily from 11/26-24 to 11/30/24 (4 days) Review of the resident's MAR dated 12/2024 revealed the resident did not receive the Prednisone 10 mg daily on 12/1/24 and 12/2/24. Review of Resident 22's Nursing Progress Notes revealed the following: -12/2/24 at 2:48 PM the resident was complaining of shortness of breath and lung sounds were diminished. -12/3/24 at 9:33 AM the resident's Prednisone 10 mg daily was not administered as it was not available. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/3/24 at 4:59 PM the resident was sent to the emergency room (ER) for evaluation. The resident from the ER with diagnosis of Bronchitis. -12/4/24 at 10:17 AM the resident's Prednisone 10 mg daily was not administered as it was not available. -12/5/24 at 2:08 PM the resident was complaining of shortness of breath with labored respirations and oxygen saturation (amount of oxygen in the blood) level was 80 percent. Lung sounds were coarse and the resident's oxygen saturation levels dropped to 71 percent. The resident was set to the ER and was admitted with diagnosis of pneumonia. During an interview on 12/16/24 at 3:29 PM, the DON confirmed the resident had signs and symptoms of a respiratory infection and was started on Prednisone 10 mg daily for 14 days. The medication was not available from the pharmacy and was not provided to the resident on 11/27/24, 11/28/24, 11/29/24, 11/30/30, 12/1/24, 12/2/24, 12/3/24 and 12/4/24 (8 days of the 14 days). The resident was seen in theER on ,d+[DATE] and then was hospitalized on [DATE] due to diagnosis of pneumonia.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.09(I) Based on observations, record review, and interview; the facility failed to review, revise, and/or implement care plan interventions to prevent falls for Residents 16, 19, and 7. The sample size was 5 and the facility census was 44. Findings are: A. Review of the facility policy Fall Management System last reviewed 12/23 revealed the following: -Residents with high risk factors identified on the Fall Risk Evaluations would have an individualized care plan developed that included measurable objectives and timeframe's, -review of the incident would include an investigation to determine probable causal factors, -the investigation would be reviewed by the interdisciplinary team, -the Resident's care plan would be updated, and -the Quality Assurance Committee would analyze trends related to falls and would determine if further intervention was needed. B. Review of Resident 16's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) dated 10/23/24 revealed the resident had moderate cognitive impairment; required assistance with dressing, transfers, toileting, and hygiene; had diagnoses of Parkinson's Disease, heart failure, and dementia; and had 2 or more falls with no injury and 1 fall with injury in the look back period. Review of Resident 16's Care Plan last revised 10/11/24 revealed the following regarding the resident: -required extensive assistance with transfers, dressing, toileting, and bed mobility, -was a high fall risk, -fall interventions included prompt response to call lights, do not leave unattended in the wheelchair in the resident room, scoop mattress to bed, bed in low position, floor mat, and grip strip material on the floor in front of the resident's recliner. Observations of Resident 16 revealed the following: -on 12/12/24 at 6:50 AM the resident was laying in bed, grip strips were not present to the floor in front of the resident's recliner, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-on 12/12/24 at 10:30 AM the resident was visiting with a visitor in the resident room, grip strips were not present to the floor in front of the resident's recliner, -on 12/12/24 at 2:20 PM the resident was sitting in the recliner with feet elevated in the resident room, grip strips were not present to the floor in front of the recliner, -on 12/16/24 at 7:45 AM the resident was resting in bed with eyes closed, grip strips were not present on the floor in front of the recliner, and -on 12/16/24 at 1:40 PM the resident was sitting in the recliner with feet elevated in the resident room, grip strips were not present to the floor in front of the recliner. Interview on 12/16/24 at 3:57 PM with the Director of Nursing (DON) revealed Resident 16 had a fall intervention to have grip strips to the floor in front of the resident's recliner. Further interview confirmed Resident 16 did not have grip strips present to the floor in front of the recliner. C. Review of Resident 19's MDS dated [DATE] revealed the resident had moderate cognitive impairment; required assistance with dressing, toileting, transfers, and hygiene; had diagnoses of a stroke, high blood pressure, dementia, Parkinson's Disease, depression, and psychotic disorder; and had 1 fall with no injury in the look back period. Review of Resident 19's Care Plan last revised 10/9/24 revealed the following regarding the resident: -required extensive assistance with toileting, transfers, dressing, and bed mobility, -was a high fall risk, and -fall interventions included: a pad call light, dycem (non-skid pad) to the wheelchair, offer a snack in the afternoon, non-skid socks, ensure the resident was wearing appropriate shoes, and keep needed items such as water within reach. Review of the facility incident reports regarding Resident 19 revealed the following: -a fall on 10/30/24 at 12:45 AM the resident was found sitting upright on the fall mat with their back against the bed. The resident stated they were picking their nose and it started bleeding and sat on the floor to get a Kleenex. No immediate intervention was implemented, -a fall on 11/28/24 at 2:44 PM the resident was found laying on the floor on the floor mat next to the resident bed. The resident thought it was time to get up. No immediate intervention was implemented, and -a fall on 11/28/24 at 8:15 PM the resident was found sitting on the floor mat with knees up to their chest. The resident was confused. No new immediate intervention implemented. Interview on 12/16/24 at 3:57 PM with the DON confirmed Resident 19's falls on 10/30/24 and 2 falls on 11/28/24 did not have new immediate interventions implemented to prevent future falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	51391 D. Review of Resident 7's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 10/18/24 revealed that resident had a diagnosis of Anemia, Non-Alzheimer Dementia, Seizure Disorder and Depression. The resident received antipsychotic, antidepressant and anticonvulsant medications and required substantial assistance with transfers and toileting hygiene. Review of Resident 7's Fall Review dated 11/25/24 revealed the resident was sitting on the floor mat next to the bed, the call light was within reach, no gripper socks were on resident's feet and resident was trying to get up on. The resident was unaware of limitations due to a cognitive decline and was confused. The intervention put into place was to complete a Situation, Background, Assessment, and Recommendation (SBAR-structured communication framework that can help teams share information about the condition of a resident). The SBAR was sent to the physician on 11/25/24 to do a urinalysis (UA- a noninvasive medical test that examined urine to check for signs of health issues) due to resident being more tired than usual. The physician's order was received on 11/26/24 to complete a UA and encourage 4 ounces of cranberry juice or another liquid for meals until symptoms resolve. The SBAR order was signed by the facility on 11/28/24, the UA was completed on 11/30/24 and on 12/2/24 UA results were sent to the facility from the physician and stated waiting for the results of a culture (a laboratory procedure where a urine sample is grown to identify specific bacteria or yeast causing an infection). On 12/16/24 the UA results were received with no treatment ordered. During an interview on 12/16/24 at 1:45 PM the DON confirmed that the UA was completed on 11/30/24 and the culture results were received from the physician on 12/16/24 with no treatment. No other fall interventions were put into place.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interview; the facility failed to ensure Residents 16 and 19 had a documented duration of use for the long-term use of antibiotics. The sample size was 2 and the facility census was 44. Findings are: A. Review of the facility policy Antibiotic Stewardship, last reviewed 12/23 revealed the following: -the Antibiotic Stewardship Program (ASP) would promote appropriate use of antibiotics while optimizing treatment of infections while reducing possible adverse events, -require antibiotic orders to include the indication, dose, and duration, -the pharmacy consultant would review and report antibiotic usage on a monthly basis, and -education opportunities, repeated regularly, would be provided as appropriate to staff and/or family. B. Review of Resident 16's Minimum Data Set (MDS-a federally mandated assessment tool used in Care Planning) dated 10/23/24 revealed the resident had moderate cognitive impairment; required assistance with dressing, transfers, toileting, and hygiene; diagnoses of Parkinson's Disease, heart failure, and dementia; was frequently incontinent of urine; and received an antibiotic. Review of Resident 16's Care Plan last revised 10/11/24 revealed the resident had a urinary tract infection and staff were to check the resident for incontinence, encourage adequate fluid intake, and give antibiotic therapy as ordered. Review of Resident 16's Medication Administration Records (MAR) revealed the resident received Bactrim DS (an antibiotic) 1 tab by mouth one time a day with an original order date of 4/3/24 during the following time periods: -October 2024: 1-31, -November 2024: 1-23, and -December 2024: 3-15. Interview on 12/11/24 at 11:22 AM with Resident 16's Power of Attorney revealed the resident was on continuous antibiotic therapy due to bladder infections. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C. Review of Resident 19's MDS dated [DATE] revealed the resident was moderately cognitive impaired; required assistance with dressing, toileting, transfers, and hygiene; had diagnoses of a stroke, high blood pressure, dementia, Parkinson's Disease, depression, and psychotic disorder; was frequently incontinent of urine; and had received an antibiotic. Review of Resident 19's Care Plan, last revised on 10/9/24 revealed the resident had bladder incontinence with a history of bladder infections; staff were to assist to bathroom after waking up, before and after meals, mid-afternoon, at bedtime, and during the night as needed; encourage fluids; and check and change when incontinent. Review of Resident 19's MAR's revealed the resident received Keflex 250 milligrams 1 capsule by mouth one time a day with an order date of 6/5/24 on the following dates: -October 2024: 1-31, -November 2024: 1-30, and -December 1-16. D. Interview on 12/16/24 at 11:25 AM with the Infection Preventionist revealed staff had reached out to the Providers with education, but the Providers continued the antibiotics for Residents 16 and 19 without stop dates. Interview on 12/16/24 at 3:57 PM with the Director of Nursing and the Infection Preventionist confirmed Residents 16 and Resident 19 were receiving antibiotics without stop dates.

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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. 51391 Licensure Reference Number 175 NAC 12-006.11E Based on observation, interview and record review; the facility staff failed to wash hands and to change gloves to prevent the potential for cross contamination during the provision of a meal service. The facility census was 44 with a total sample size of 44. Findings are: A. Review of the Drug Administration Food Code and used as an authoritative reference for food service sanitation practices, revealed the following: -2-310.14 Food employees shall wash their hands and exposed portions of their arms immediately before engaging in food preparation: -after handling soiled equipment or utensils; and -during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. -3.304.15 (A) Single use gloves shall be used for only one task and should be discarded when soiled or when interruptions occur in the operation. B. During observation of the noon meal service on 12/12/24 at 12:00 PM to 12:40 PM, Dietary [NAME] (DC)-P with gloved hands placed piece of pork loin on the dinner plate, was touching the meat when cutting it into small pieces. DC-P did not change gloves after touching the meat, then touched various kitchen items including resident cards, dishes and serving utensils without changing gloves or washing hands. Interview with Dietary Manager (DM)-Q on 12/12/24 at 2:30PM confirmed staff should have removed gloves after touching the food, washed hands and put on a clean pair of disposable gloves before touching other kitchen items.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.18 Based on observation, record review, and interview the facility failed to complete hand hygiene at appropriate intervals to prevent the potential spread in infection for Residents 17, 11, and 7, failed to utilize the appropriate Personal Protective Equipment (PPE-the use of protective clothing such as gowns, gloves, or other measures such as face/eye protection used to prevent the spread of infection and or protect care-givers during care) during the provision of care for Residents 34 and 7 who were on Enhanced Barrier Precaution (EBP-infection prevention through expanded use of PPE), and failed to develop and implement measures to prevent the growth of potential water borne illness. The sample size was 21 and the facility census was 44. Findings are: A. Review of the facility policy for Standard and Transmission-Based Precautions with a revision date of 3/2024 revealed the following: -It was the facility policy to implement infection control measures to prevent the spread of communicable diseases and conditions, -balance infection risk factors that increased the likelihood of transmission, -utilized the least restrictive approach possible to adequately protect residents and others, -the use of Enhanced Barrier Precaution (EBP) was used in conjunction with Standard Precautions (infection prevention practices that applied to the care of all residents regardless of suspected or confirmed infection), through expanded use of Personal Protective Equipment (PPE-a term to describe the use of protective clothing such as gowns, gloves, or other measures such as face/eye protection used to prevent the spread of infection and or protect care-givers during care), through the use of gown and gloves during high-contact resident care activities with residents infected or colonized (the presence of an organism without active infection) with Multidrug Resistant Organisms (MDRO's-multidrug resistant organisms that are resistant to multiple antibiotic or antimicrobial agents), -high contact care activities included residents with chronic wounds, indwelling medical devices, and the care of residents with MRDO's (including dressing, bathing, transferring, providing hygiene, changing linens, changing brief or assisting with toileting). B. Review of the undated facility policy Handwashing revealed the purpose was to provide good hygiene, infection control, and a healthy environment and revealed that hands had to be washed or sanitized with hand sanitizer before and after each glove use and between all glove changes. C. Review of Resident 17's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 10/9/24 revealed the resident was dependent for toileting hygiene, received substantial assistance with dressing and received partial assistance with personal and oral hygiene. The resident was frequently incontinent of bladder and involuntary of bowel. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 17's Care Plan with a revision date of 10/24/24 revealed the resident required hands on assistance with washing hands, adjusting clothing, cleaning self, and transferring and bed mobility. During an observation of the provision of care for Resident 17 on 12/12/24 at 8:12 AM Nurse Aid (NA)- entered the resident room, did not perform hand hygiene, put on disposable gloves, assisted the resident into a sitting position on the edge of the bed. NA- then identified there was not a sling available for the stand-up mechanical lift so she assisted the resident to lay back down and removed the gloves and again did not perform hand hygiene and exited the room to retrieve a sling for the lift. NA- again entered the room, did not perform hand hygiene and put another pair of disposable gloves on. She secured the resident with the sling, lifted the resident into a standing position, pulled up the resident's pants and transferred the resident into a wheelchair. Again NA - removed the gloves and did not perform hand hygiene before putting on clean gloves. NA- then obtained a washcloth from the bathroom and assisted the resident to wash the face, then retrieved the resident partial denture and put it in the resident's mouth and assisted in brushing teeth, retrieved a comb and combed the resident's hair then removed the gloves and again did not perform hand hygiene and assisted the resident to the dining room in the wheelchair. During an interview on 12/17/24 at 1:04 PM the Director of Nursing (DON) confirmed staff should wash their hands whenever they enter a resident's room, before putting on clean gloves and whenever removing soiled gloves. 51391 D. During an observation of the provision of care for Resident 11 on 12/12/24 at 7:25 AM, NA-C provided toileting and incontinence cares. NA-C entered the resident's room and without washing hands or completing hand hygiene placed disposable gloves on both hands and transferred the resident from the wheelchair to the toilet using the mechanical lift, NA-C removed the resident's incontinent brief which was soiled with urine. NA-C provided toileting hygiene, removed soiled gloves, and still did not complete hand hygiene, then put on clean disposable gloves and placed a clean incontinence brief on the resident. NA-C then adjusted the resident's clothing and transferred the resident into the wheelchair. NA-C removed soiled gloves, cleaned off the mechanical lift and exited the resident's room without washing hands or completing hand hygiene. During an interview on 12/12/24 at 8:00 AM, NA-C, confirmed staff were to wash hands or to use hand sanitizer when entering the resident's room for cares, when removing gloves and when exiting the resident's room. E. Review of the EBP sign posted on Resident 7's room door, from the U.S. Department of Health and Human Services Center for Disease Control and Prevention revealed the following: For EBP Everyone Must: -Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: -Wear gloves and a gown for the following High Contact Resident Care Activities: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dressing Bathing/Showering Transferring Changing Linens Providing Hygiene Changing briefs or assisting with toileting -Device care or use of the following: A central line, urinary catheter, feeding tube, or tracheostomy. Wound Care for any skin opening requiring a dressing. Review of Resident's 7 Minimum Data Set (MDS - federally mandated comprehensive assessment use to develop resident care plans) dated 10-18-24 revealed the resident had a stage 4 pressure ulcer (the most severe stage of a pressure sore, where the damage extends fully through the skin layers, exposing underlying muscle, tendon, or bone, often visible dead tissue and a high risk of infection) and required substantial assistance with toileting hygiene, bathing, upper body dressing, personal hygiene, bed mobility and transfers and was dependent on staff for lower body dressing and putting on footwear. Review of Resident 7's Care Plan with a date of 11/04/24 revealed the resident had a stage 4 pressure ulcer to the coccyx (last bone at the base of your spine). The resident was on EBP during the provision of close contact care. Review of Resident 7's Treatment Administration Record (TAR) dated December 2024 revealed an order for: -Wound care to medial coccyx-cleansed with normal saline, apply aquacel ribbon to wound. Cover with 4X4 comfort foam border, changed daily and -Enhanced Barrier Precautions for high resident contact activities related to a coccyx wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation of the provision of care for Resident 7 on 12/16/24 at 7:00 AM, NA-K and NA-L provided toileting and incontinence cares. NA-K had disposable gloves on both hands, NA-L entered the room, washed hands and placed disposable gloves on both hands, neither staff put on gowns. The staff transferred the resident from the wheelchair to the toilet, NA-K removed the resident's incontinent brief, which was soiled with urine, provided toileting hygiene, removed soiled gloves, did not wash hands, put on clean disposable gloves and placed a clean incontinence brief on the resident. NA-K then adjusted the resident's clothing and transferred the resident into the wheelchair, removed the disposable gloves, completed hand hygiene with soap and water and applied clean disposable gloves, then assisted resident with washing hands and face and brushing teeth. NA-L removed the disposable gloves, picked up dirty linens and placed them in a bag, did not complete hand hygiene before leaving the room. The episode of care was provided without wearing the required gown. During an interview on 12/16/24 at 7:30 AM, NA-K verified that Resident 7 was on EBP, gown and gloves should have been worn during high contact resident care and confirmed that no gown was worn when completing cares with the resident. NA-K further confirmed staff were to wash their hands after removal after assisting the resident with toileting hygiene was completed. During an interview on 12/16/24 at 7:30 AM, NA-L verified that Resident 7 was on EBP, gown and gloves should have been worn during high contact resident care and confirmed that no gown was worn when completing cares with the resident. NA-L further confirmed staff were to wash their hands or to use hand sanitizer when removing soiled gloves and when exiting the resident's room. During an interview on 12/16/24 at 8:00 AM, the DON verified that Resident 7 was on EBP, staff should be following the EBP sign on the door and should have been washing their hands following the handwashing policy, washing hands before and after each glove use and between all glove changes. 45739 F. Observation on 12/12/24 at 10:15 AM with LPN-F put a gown on, entered Resident 34's room, performed hand hygiene, and put on gloves. NA-E entered the resident room, performed hand hygiene, put on gloves, and went to the resident's bedside to assist LPN-F. NA-E was not wearing a gown. NA-E, still not wearing a gown assisted Resident 34 to roll to their left side. NA-E's scrub top was touching the residents bed linens. LPN-F performed wound care without any identified concerns. NA-E, still not wearing a gown and LPN-F removed the resident's old brief and applied a new brief. LPN-F then removed their gown and gloves, performed hand hygiene and put on new gloves. LPN-F, without a gown on, went to the resident's bedside to apply biofreeze (a topical pain relief gel used to treat minor aches and pains) to the resident's knees. LPN-F's scrub top and pants were touching the residents bed linens. LPN-F and NA-E covered the resident up, removed their gloves and performed hand hygiene. NA-E removed the trash from the room and disposed of in the appropriate receptacle and performed hand hygiene. 12/12/24 at 2:15 PM interview with NA-E revealed staff only needed to gown if they would be touching the wound. Further interview confirmed NA-E was not wearing a gown during high contact cares. 12/12/24 at 11:25 AM interview with the Infection Preventionist revealed PPE should be worn (gown and gloves) with all high contact cares for residents on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/12/24 at 3:49 PM interview with LPN-F confirmed LPN-F was not wearing a gown for the duration of assisting Resident 34 and that LPN-F should have continued to wear PPE to prevent contact with the bed linens. 12/16/24 at 3:57 PM interview with the DON confirmed gown and gloves should be worn during high contact care for residents on EBP. 29638 G. 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 manufactured water systems) with a revision date of 10/24 revealed the following: -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 was to develop and maintain a water management program that included development of 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 was to establish control measures monitoring temperature and disinfectant levels to prevent water stagnation and bacteria growth. During an interview on 12/16/24 at 12:25 PM, the Administrator and the Maintenance Supervisor confirmed the following: -no risk assessment had been completed to identify and evaluate potential sources and areas of risk where Legionella and other waterborne pathogens could grow and spread. -the facility had not identified and/or implemented measures to prevent the growth of Legionella in the facility water systems.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 License Reference Number: 175 NAC 12-006.18(A) Based on record review and interviews; the facility failed to ensure 3 (Residents 31, 197 and 244) of 5 sampled residents were offered the Pneumococcal and the Influenza vaccines and/or were educated about the risks and benefits associated with the vaccines. The facility census was 44. Findings are: A. Review of the facility policy Immunizations-Residents with a revision date of 10/24 revealed the receipt of vaccinations was essential to the health and well-being of long-term care residents. Establishment of an immunization program against influenza and pneumococcal disease facilitated achievement of this objective. The following procedures were identified; -residents were to be screened at admission to determine vaccine status and eligibility using current Centers for Disease Control (CDC) guidelines, to receive influenza and pneumococcal vaccines and then annually for the influenza vaccine. -before offering the vaccine each resident and/or their representative were to receive education regarding the benefits and potential side effects of the immunizations. Information related to education or refusal of the vaccine was to be documented in the resident's medical record. -the vaccine could be offered and administered if the benefits of the vaccine outweighed the risks, the resident or the resident's representative provided consent and the resident's physician approved. -individual resident information was to be documented in the resident's electronic medical health record. B. Review of Resident 31's electronic medical record revealed the resident was admitted to the facility on [DATE]. There was no evidence the facility had screened Resident 31 to determine the resident's vaccination status, education was provided regarding the risks and benefits associated with the influenza and pneumococcal vaccines, or the resident was offered and/or received the influenza/ pneumococcal vaccines. C. Review of Resident 197's electronic medical record revealed the resident was admitted to the facility on [DATE]. There was no evidence the facility had screened Resident 197 to determine the resident's vaccination status, education was provided regarding the risks and benefits associated with the influenza and pneumococcal vaccines, or the resident was offered and/or received the vaccines. D. Review of Resident 244's electronic medical record revealed the resident was admitted to the facility on [DATE]. There was no evidence the facility had screened Resident 244 to determine the resident's vaccination status, education was provided regarding the risks and benefits associated with the influenza and pneumococcal vaccines, or the resident was offered and/or received the influenza/ pneumococcal vaccines. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. During an interview with the Director of Nursing (DON) on 12/17/24 at 11:11 AM, the DON, confirmed the facility did not have a process in place and no staff were responsible for screening the resident's immunization status at admission. The DON further confirmed there was no evidence Residents 31, 197 and 244 or their responsible parties received education regarding the risks or benefits of the immunizations and were offered and provided the vaccines for influenza and pneumococcal.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 License Reference Number: 175 NAC 12-006.18(A) Based on record review and interviews; the facility failed to provide evidence 3 (Residents 31, 197 and 244) of 5 sampled residents were offered the COVID-19 vaccine and/or were educated about the risks and benefits associated with the vaccines. The facility census was 44. Findings are: A. Review of the facility policy Immunizations-Residents with a revision date of 10/24 revealed the receipt of vaccinations was essential to the health and well-being of long-term care residents. Establishment of an immunization program against influenza and pneumococcal disease facilitated achievement of this objective. The following procedures were identified; -residents were to be screened at admission to determine vaccine status and eligibility using current Centers for Disease Control (CDC) guidelines, to receive COVID-19 vaccine. -before offering the vaccine each resident and/or their representative were to receive education regarding the benefits and potential side effects of the immunizations. Information related to education or refusal of the vaccine was to be documented in the resident's medical record. -the vaccine could be offered and administered if the benefits of the vaccine outweighed the risks, the resident or the resident's representative provided consent and the resident's physician approved. -individual resident information was to be documented in the resident's electronic medical health record. B. Review of Resident 31's electronic medical record revealed the resident was admitted to the facility on [DATE]. There was no evidence the facility had screened Resident 31 to determine the resident's vaccination status, education was provided regarding the risks and benefits associated with the COVID-19 vaccine, or the resident was offered and/or received the vaccine. C. Review of Resident 197's electronic medical record revealed the resident was admitted to the facility on [DATE]. There was no evidence the facility had screened Resident 197 to determine the resident's vaccination status, education was provided regarding the risks and benefits associated with the COVID-19 vaccine, or the resident was offered and/or received the vaccine. D. Review of Resident 244's electronic medical record revealed the resident was admitted to the facility on [DATE]. There was no evidence the facility had screened Resident 244 to determine the resident's vaccination status, education was provided regarding the risks and benefits associated with the COVID-19 vaccine, or the resident was offered and/or received the vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. During an interview with the Director of Nursing (DON) on 12/17/24 at 11:11 AM, the DON, confirmed the facility did not have a process in place and no staff were responsible for screening the resident's immunization status at admission. The DON further confirmed there was no evidence Residents 31, 197 and 244 or their responsible parties received education regarding the risks or benefits of the COVID-19 immunization and were offered and provided the vaccine.