STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285164	A. Building B. Wing	01/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holmes Lake Rehabilitation & Care Center	6101 Normal Blvd Lincoln, NE 68506

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 42861 Licensure Reference Number 175 NAC 12-006.04C3a(5) Based on interview and record review the facility failed to have a nursing services representative present during the care plan conferences for 4 (Residents 1, 4 and 6) of 4 sampled residents. The facility identified a census of 52. Findings are: A record review of the facility policy dated 9/2019 and titled Care Plan Process revealed that that Care Plan Conferences should include the resident, Family/Legal Representative (if the resident is not able to attend or gives approval for participations, Clinical Reimbursement Manager/ MDS (Minimum Data Set, a comprehensive assessment of each resident's physical and mental functional capabilities) Coordinator, Director of Nursing Services or Registered Nurse (RN) designee and that the signature of the DON or designee indicated knowledge of the care plan and that is appropriate for the residents's needs. A record review of the Care Plan Conference note dated 9/17/24 for Resident 6 revealed no one from nursing services attended the Care Plan Conference. A record review of the Care Plan Conference note dated 1/2/25 for Resident 4 revealed no one from nursing services attended the Care Plan Conference. A record review of the Care Plan Conference note dated 9/17/24 and 12/31/24 for Resident 1 revealed no documentation that nursing services attended these Care Plan Conferences. An interview on 1/9/25 at 12:29 PM with the facility Administrator revealed that the DON (Director of Nursing) was expected to attend Care Plan Conferences for nursing services representation. ADM confirmed that the DON did not attend Residents 1, 4, 6 Care Plan Conference.

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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45613 Licensure Reference Number 175 NAC 12.00610(D) Based on observation, record review and interview, the facility failed to ensure1 resident (Resident 3) of 5 sampled residents were free from significant medication errors. The facility census is 52. Findings are: Record review of the facility's undated policy, titled Using the Flexpen Insulin Competency revealed instructions to dial a test dose of 2 units, hold the pen upright and tap to bring any bubbles to the top. Prime the pen and dial the ordered dose before injecting dose. Record review of Diabetes Journal article titled Insulin Pen Priming dated [DATE] revealed priming an insulin pen is recommended to remove air bubbles from needle to ensure the full dose of insulin. If you do not prime the pen before each injection, you may get too much or too little insulin. An observation on 1/8/25 at 9:09 AM Registered Nurse (RN) - A completed an accucheck on Resident 3. The resident was lying in bed and stated (gender) had not eaten breakfast yet. RN - A applied gloves and prepped the area, then injected the insulin pen into the resident's left arm then dialed the pen and injected the insulin. The nurse did not prime the pen. In an interview on 1/8/25 at 9:10 AM RN - A confirmed that (gender) did not dial the prescribed dose of insulin or prime the pen before injecting Resident 3 with insulin but should have. Record review of Resident 3's entry Minimum Data Set (MDS - a comprehensive assessment of each resident's functional capabilities used to develop a resident's plan of care) dated 12/31/24 revealed that the resident was admitted to the facility on [DATE] with an active diagnosis of Type 2 Diabetes Mellitus. Review of Resident 3's physician orders dated 12/31/24 revealed order for Insulin Glargine (long acting) inject 20 units subcutaneously twice daily. Review Resident 3's Treatment Administration Record (TAR) for January 2025 revealed an order dated 1/6/25 to increase Insulin Glargine to 20 units in the morning and 22 units in the evening. In an interview on 1/13/24 at 8:06 AM the Administer (Adm) confirmed that the insulin pen should have been primed and dialed to dose before injecting the insulin into resident 3 to ensure an accurate dose. In an interview on 1/13/25 at 12:34 PM the Regional Nurse Consultant (RNC) confirmed there were 13 residents in the facility that required injectable insulin.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42861 Licensure Reference Number 175 NAC 12-006.17D Based on observation, interview and record review the facility failed to ensure infection control procedures were followed and maintained during peri cares (the process of washing the genitals and anal area) for one (Resident 11) of two residents sampled. The facility identified a census of 52. Findings are: A record review of the document titled Admission Record, printed on 1/9/25, revealed Resident 11 admitted to the facility on [DATE] with a primary diagnosis of cerebral infarct (occurs when blood flow is blocked causing brain tissue to die). An observation on 1/9/25 at 12:02 PM, accompanied by the facility's Regional Nurse Consultant, revealed Nurse Aide (NA)-F preparing to toileting Resident 11. During the observation NA-F ambulated Resident 11 to the bathroom, assisted [gender] onto the toilet, pulled down Resident 11's pants and soiled brief without gloves on. NA-F then performed hand hygiene and applied gloves. Next NA-F removed Resident 11's shoes, pants and soiled brief, applied a clean brief and then had Resident 11 stand and proceeded to wipe the peri/rectal area without performing hand hygiene or changing gloves. An interview on 1/9/25 at 12:12 PM with the facility Regional Nurse Consultant confirmed that NA-F did not change gloves after removing shoes, clothing and soiled brief and prior to providing perineal cares and should have. An interview on 1/9/25 at 12:12 PM with NA-F confirmed that [gender] did not change gloves after removing shoes, clothing and soiled brief and prior to providing perineal cares and should have.