

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Holmes Lake Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641</p> <p>Licensure Reference Number 175 NAC 12.006.04(F)(i)(5)</p> <p>Based on interview and record review, the facility failed to ensure 2 (Residents 23 and 38) of 4 sampled resident's representative was notified following all falls. The facility census was 47.</p> <p>Findings are:</p> <p>A record review of the facility's Fall Management policy with a last date revised of 01/2024 revealed after a resident's fall, the facility would contact the physician and family and document in the medical record, including time and person spoken with.</p> <p>A.</p> <p>A record review of Resident 23's Clinical Census dated 10/07/2024 revealed the resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 23's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to develop a resident's care plan) dated 07/23/2024 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) of 3 out of 15 that indicated the resident was severely cognitively impaired. The MDS revealed the resident had fallen in the last 2-6 months.</p> <p>A record review of the facility's Incident By Incident Type log dated 10/02/2024 revealed Resident 23 had fallen on 01/04/2024, 04/22/2024, 08/27/2024, 09/24/2024, and 10/02/2024.</p> <p>A record review of Resident 23's Progress Notes dated 10/07/2024 revealed the resident fell from the recliner on 10/02/2024 and the progress note did not reveal evidence that the family/Power of Attorney (POA, person assigned to make decisions for another person) was notified.</p> <p>A record review of Resident 23's Fall (Un-witnessed) document dated 10/02/2024 revealed the resident fell from a power lift recliner and the person listed as being notified was the Nurse Practitioner. It did not reveal evidence that the family had been notified of the fall.</p> <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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/08/2024 at 9:51 AM, Resident 23's family member/POA confirmed the POA was upset and concerned because the facility did not notify the family of the resident's fall on 10/02/2024. The family member/POA confirmed they found out by accident a couple of days later when the family was at the facility.</p> <p>In an interview on 10/08/2024 at 2:15 PM the facility's Clinical Nurse Consultant (CN) confirmed the resident's representative was not notified following the 10/02/2024 fall and should have been.</p> <p>42861</p> <p>B.</p> <p>A record review of the document titled Admission Record revealed Resident 38 had been admitted to the facility on [DATE] with a primary diagnosis of multiple right rib fractures with acute pain due to trauma.</p> <p>A record review of the Minimum Data Set (MDS, a federally mandated comprehensive assessment of each resident's physical and mental functional capabilities) dated 6/25/24 revealed that Resident 38 had a Brief Interview for Mental Status (BIMS, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function, while scores of 00 or 99 indicate total confusion) score of 8, which indicated the resident's cognition was moderately impaired.</p> <p>A record review conducted on 10/02/24 at 10:07 AM of the Facility Incident Log dated 10/2/23 through 10/2/24 revealed Resident 38 had had 2 recent falls on 9/18/24 and 9/24/24.</p> <p>An interview on 10/02/24 at 10:33 AM revealed that Resident 38's representative had not been notified of the resident's falls on 9/18/24 and 9/24/24.</p> <p>A record review of Resident 38's Progress Notes dated 6/1/24 through 10/8/24 revealed Resident 38 did have a fall on 9/18/24 and the Progress Notes read as follows;</p> <p>-9/18/2024 at 5:43 PM Resident observed lying on side in hallway, several staff nearby rushed to assist. Neuro checks negative for head injury. See risk management report for full synopsis. VSS (vital signs stable) NP (Nurse Practitioner) notified via fax. Resident is own responsible party, so family was not called. Resident denies pain or injury. Confused. Oriented to self only. Skin appears to be without injury. Resident advised to use call light for assistance when ambulating until we receive direction from MD (Medical Doctor) or NP. Resident indicates understanding but remains confused.</p> <p>The record review of the Progress Notes dated 6/1/24 through 10/8/24 for Resident 38 related to the fall revealed no documentation of family or representative notification nor any follow up documentation post fall.</p> <p>An interview with the facility Administrator on 10/08/24 at 1:55 PM confirmed that the expectation was that family/resident representative be notified along with the physician on any and all falls.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42861</p> <p>Licensure Reference Number 175 NAC 12-006.09</p> <p>Based on interview and record review the facility failed to provide bathing services as required for four (Residents 2, 31, 35 and 38) of eight sampled residents. The facility identified a census of 47.</p> <p>Findings are:</p> <p>A record review of the facility policy titled Activities of Daily Living (ADLs) dated 1/2024, revealed that ADL's included the resident's ability to bathe, dress and groom but did not indicate a frequency related bathing.</p> <p>A.</p> <p>A record review of the document titled Admission Record revealed Resident 2 had been admitted to the facility on [DATE] with a primary diagnosis of Dementia (general term that represents a group of diseases and illnesses that affect your thinking, memory, reasoning, personality, mood and behavior) with behavioral disturbances.</p> <p>A record review of the Minimum Data Set (MDS, a federally mandated comprehensive assessment of each resident's physical and mental functional capabilities) dated 8/2/24 revealed that Resident 2 had a Brief Interview for Mental Status (BIMS, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function, while scores of 00 or 99 indicate total confusion) score of 9, which indicated the resident had moderately impaired cognition.</p> <p>A record review conducted on 10/08/24 at 8:03 AM of the bathing logs titled Documentation Survey Report V2, Intervention/Task, ADL-bathing for Resident 2 over the prior 90 days revealed that no bath had been given or no refusal had been documented from 8/22/24 to 9/1/24 for a total of 10 days and also 9/19/24 to 10/3/24 for a total of 15 days.</p> <p>A record review of the undated, active Care Plan for Resident 2 revealed no evidence of bathing preference related to bathing frequency for Resident 2.</p> <p>An interview on 10/7/24 at 3:16 PM with Nurse Aide (NA)-J confirmed that the facility had no specific bath aide and that all NAs gave resident baths daily according to a list posted at the nurses' station.</p> <p>B.</p> <p>A record review of the document titled Admission Record revealed Resident 35 had been admitted to the facility on [DATE] with a primary diagnosis of protein calorie malnutrition, severe.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A record review of the MDS dated [DATE] revealed that Resident 35 had a BIMS score of 00/15, which indicated the resident had severe cognitive impairment.</p> <p>A record review completed on 10/08/24 at 8:03 AM of the bathing logs titled Documentation Survey Report V2, Intervention/Task, ADL-bathing for Resident 35, for the prior 90 days, revealed that no bath had been given or refused from 8/12/24 through 8/25/24 for a total of 13 days, no bath had been documented as given or refused from 8/26/24 through 9/22/24 for a total of 27 days, and on 9/22/24 ADL-Bathing had been documented as NA meaning not applicable and no other documentation related to bathing had been done until a refusal was documented on 9/29/24.</p> <p>An interview on 10/7/24 at 3:16 PM with NA-J confirmed that the facility had no specific bath aide and that all NAs gave resident baths daily according to a list posted at the nurses' station.</p> <p>A record review of the undated, active care plan for Resident 35 revealed no bathing preference related to frequency of bathing.</p> <p>C.</p> <p>A record review of the document titled Admission Record revealed Resident 38 had been admitted to the facility on [DATE] with a primary diagnosis of multiple right rib fractures and acute pain due to trauma.</p> <p>A record review of the MDS dated [DATE] revealed that Resident 38 had a BIMS score of 8/15, which indicated the resident had moderately impaired cognition.</p> <p>A record review conducted on 10/08/24 at 8:03 AM of the bathing logs titled Documentation Survey Report V2, Intervention/Task, ADL-bathing for Resident 38 over the prior 90 days revealed that no bath had been given or refused from 8/23/24 to 9/1/24 for a total of 9 days and from 9/23/24 to 10/3/24 for a total of 11 days.</p> <p>An interview on 10/3/24 at 12:51 PM with the DON, after review of the bathing logs for Resident 38, confirmed that bathing is slim. The DON voiced awareness of the lack of bathing and voiced that a PIP had been initiated 3 days prior however no audits had been completed yet to show any kind of improvement in the bathing or frequency of. During the interview, the DON confirmed that the facility expectation was that all residents received a minimum of one bath weekly.</p> <p>A record review of the undated, active care plan for Resident 38 revealed no bathing preference related to frequency of bathing.</p> <p>An interview on 10/7/24 at 3:16 PM with NA-J confirmed that the facility had no specific bath aide and that all NA's gave resident baths daily according to a list posted at the nurses' station.</p> <p>An interview on 10/3/24 at 12:51 PM with the Director of Nursing (DON), after review of the bathing logs for Residents 2, 35, and 38, confirmed that bathing is slim. The DON voiced awareness of the lack of bathing and voiced that a PIP (Process Improvement Plan) had been initiated 3 days prior however no audits had been completed to show any kind of improvement in the bathing or frequency of bathing. During the interview, the DON confirmed that the facility expectation was that all residents received a minimum of one bath weekly.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>50683</p> <p>D.</p> <p>An interview on 10/07/2024 at 1:31 PM with Resident 31 revealed that Resident 31's bath days were on Mondays and Thursdays, but they had only received 1 (one) shower in the prior 4 (four) weeks and they got shaved in the shower.</p> <p>An observation on 10/07/2024 at 1:45 PM revealed Resident 31 had facial hair growth on cheeks, chin and above and below lips. Resident 31 stated I like to be clean shaven, at least once a week.</p> <p>A record review of facility provided documentation revealed that Resident 31's last shower was on 08/29/2024, which indicated that the resident hadn't had a shower in 39 days.</p> <p>A record review of Resident 31's care plan, reviewed on 10/08/2024 revealed no bathing preferences.</p> <p>A record review of a bathing list that was posted at the nurse's station revealed Resident 31 was on the schedule to receive a shower on Mondays and Thursdays, in the morning.</p> <p>An interview with the Director of Nursing (DON) on 10/07/2024 at 3:40 PM confirmed that it was the facility's expectation that all residents were provided with personal hygiene including bathing services, and that baths were to be given at least weekly.</p> <p>E.</p> <p>Based on observation, record review and interview, the facility failed to change Resident 31's indwelling catheter monthly per the resident's physician's order. The sample size was 1 and the facility census was 47.</p> <p>Findings are:</p> <p>Record review of Resident 31's Clinical Census dated 10/02/2024, revealed the resident was admitted to the facility on [DATE].</p> <p>Record review of the Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated August 12, 2024 revealed the following related to Resident 31:</p> <ul style="list-style-type: none"> -The resident had a Brief Interview for Mental Status (BIMS, a brief assessment used to determine cognitive ability) score of 12 out of 15 which indicated the resident had moderately impaired cognition. -The resident required substantial/maximal assistance with toileting hygiene. -The resident had an indwelling urinary catheter (a small tube that is inserted into the bladder to drain urine that drains into a urinary collection bag) often referred to as a Foley catheter. <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident had a diagnosis of Neurogenic Bladder (a condition where the nerves along the pathway between the bladder and the brain do not work properly resulting urine being retained in the bladder).</p> <p>An observation on 10/2/2024 at 1:50 PM of Resident 31 revealed that the resident had an indwelling catheter that was connected to a leg bag (a small urinary collection bag that is secured to the leg).</p> <p>An interview with Resident 31 on 10/02/2024 at 1:50 PM confirmed that they had an indwelling catheter and that the facility was supposed to change the catheter every 4 weeks but the catheter had not been changed in months.</p> <p>A record review of Resident 31's Physician Orders revealed an order dated 07/31/2024 that stated to change the resident's catheter every month using a latex-free catheter.</p> <p>A record review of Resident 31's Progress Note on 07/20/2024 at 6:16 AM revealed Unable to irrigate Foley, has leaked around cath with almost no output per foley, replaced foley with 16FR foley per sterile technique, instilled 25 cc water into balloon, resident is upset that foley was clogged and (gender) sleep was interrupted, (gender) did allow CNAs to change (gender) brief.</p> <p>A record review of Resident 31's Progress Note on 08/31/2024 at 6:27 AM revealed that the Foley catheter did not get changed because Latex free catheter unavailable.</p> <p>A record review of Resident 31's Progress Note on 09/30/2024 at 12:37 AM revealed Latex free catheter unavailable. Note left to have them ordered.</p> <p>An interview on 10/08/2024 at 10:15 AM with the Director of Nursing confirmed that Resident 31's last indwelling Foley catheter change was on 07/20/24 and that their catheter should have been changed every month and had not been.</p> <p>NE004</p> <p>Licensure Reference Number 175 NAC 12-006.09(H)(iv)</p> <p>Based on observation, record review and interview, the facility failed to change Resident 31's indwelling catheter monthly per the resident's physician's order. The sample size was 1 and the facility census was 47.</p> <p>Findings are:</p> <p>Record review of Resident 31's Clinical Census dated 10/02/2024, revealed the resident was admitted to the facility on [DATE].</p> <p>Record review of the Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used for care planning) dated August 12, 2024 revealed the following related to Resident 31:</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-The resident had a Brief Interview for Mental Status (BIMS, a brief assessment used to determine cognitive ability) score of 12 out of 15 which indicated the resident had moderately impaired cognition.</p> <p>-The resident required substantial/maximal assistance with toileting hygiene.</p> <p>-The resident had an indwelling urinary catheter (a small tube that is inserted into the bladder to drain urine that drains into a urinary collection bag) often referred to as a Foley catheter.</p> <p>-The resident had a diagnosis of Neurogenic Bladder (a condition where the nerves along the pathway between the bladder and the brain do not work properly resulting urine being retained in the bladder).</p> <p>An observation on 10/2/2024 at 1:50 PM of Resident 31 revealed that the resident had an indwelling catheter that was connected to a leg bag (a small urinary collection bag that is secured to the leg).</p> <p>An interview with Resident 31 on 10/02/2024 at 1:50 PM confirmed that they had an indwelling catheter and that the facility was supposed to change the catheter every 4 weeks but the catheter had not been changed in months.</p> <p>A record review of Resident 31's Physician Orders revealed an order dated 07/31/2024 that stated to change the resident's catheter every month using a latex-free catheter.</p> <p>A record review of Resident 31's Progress Note on 07/20/2024 at 6:16 AM revealed Unable to irrigate Foley, has leaked around cath with almost no output per foley, replaced foley with 16FR foley per sterile technique, instilled 25 cc water into balloon, resident is upset that foley was clogged and (gender) sleep was interrupted, (gender) did allow CNAs to change (gender) brief.</p> <p>A record review of Resident 31's Progress Note on 08/31/2024 at 6:27 AM revealed that the Foley catheter did not get changed because Latex free catheter unavailable.</p> <p>A record review of Resident 31's Progress Note on 09/30/2024 at 12:37 AM revealed Latex free catheter unavailable. Note left to have them ordered.</p> <p>An interview on 10/08/2024 at 10:15 AM with the Director of Nursing confirmed that Resident 31's last indwelling Foley catheter change was on 07/20/24 and that their catheter should have been changed every month and had not been.</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641</p> <p>Licensure Reference Number 175 NAC 12-006.09(I)</p> <p>Based on interview and record review, the facility failed to ensure interventions were implemented to prevent falls for 1 (Resident 23) of 5 sampled residents. The facility census was 47.</p> <p>Findings are:</p> <p>A record review of the facility's Fall Management policy with a last date revised of 01/2024 revealed that after a resident falls, the facility would assess and review resident risk factors and implement appropriate interventions to reduce the risk of falls. The facility would adjust/add interventions on the plan of care and educate the staff, resident, and family.</p> <p>A.</p> <p>A record review of Resident 23's Clinical Census dated 10/07/2024 revealed the resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 23's Medical Diagnosis dated 09/04/2024 revealed the resident had diagnoses of Muscle Weakness, History Of Falling, Alzheimer's Disease, Difficulty Walking, Acute On Chronic Diastolic (Congestive) Heart Failure, Acute Respiratory Failure, and Other Pulmonary Embolism (clot in the lungs).</p> <p>A record review of Resident 23's MDS dated [DATE] revealed the resident had a BIMS score of 3 out of 15 which indicated the resident was severely cognitively impaired. The resident required partial/moderate assistance with personal and oral hygiene (cleaning), and was dependent on staff for dressing, bathing, and toileting. The resident required substantial/maximal assistance with sit to stand positioning, chair to bed transfer, and toilet transfer and was dependent on staff for tub/shower transfers. The MDS revealed the resident had fallen in the last 2-6 months.</p> <p>A record review of the facility's Incident By Incident Type log dated 10/02/2024 revealed Resident 23 had falls on 01/04/2024, 04/22/2024, 08/27/2024, 09/24/2024, and 10/02/2024.</p> <p>A record review of Resident 23's Progress Notes reviewed on 10/07/2024 revealed:</p> <ul style="list-style-type: none"> - 9/24/2024 - the resident was playing with the power recliner remote and lifted the chair all the way up and slid out onto the floor. - 10/02/2024 - the power recliner was raised to the standing position and the staff found the resident on the floor in front of the power recliner. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the facility's Fall report dated 09/24/2024 revealed Resident 23 was playing with the power recliner remote and lifted the chair all the way up and slid out onto the floor. The resident was alert and oriented to person only per baseline. The resident had no injuries. Predisposing environmental factors was furniture. Predisposing physiological factors included confused and weakness. Under Other Information it revealed the resident playing with recliner remote.</p> <p>A record review of the facility's Fall (un-witnessed) report dated 10/02/2024 revealed the power recliner was raised to the standing position and the staff found Resident 23 on the floor in front of the power recliner. The resident was alert and oriented to person, place, and situation. The resident had no injuries. Predisposing environmental factors was none. Predisposing physiological factors included impaired memory.</p> <p>A record review of Resident 23's Care Plan with an admitted [DATE] revealed the resident needed 2 staff and a Hoyer lift (full body lift) for transfers. The resident was experiencing cognitive function/dementia. The resident has had an actual fall and was at high risk for falls related to unsteady gait. The Care Plan did not reveal new interventions for the 09/24/2024 and 10/02/2024 falls.</p> <p>A record review of the facility's Clinical document dated 09/01/2024 through 09/27/2024 revealed Resident 23's 09/24/2024 fall was on the list and an intervention was: Make sure feet elevated when resident is. The question for Risk Management Completed? was marked in progress and the question for Care Plan Updated? was blank.</p> <p>A record review of the facility's Clinical document dated 08/12/2024 through 10/09/2024 revealed Resident 23's 10/02/2024 fall was on the list and an intervention was: remote to side of recliner. The question for Risk Management Completed? was marked in progress and the question for Care Plan Updated? was blank.</p> <p>A record review of the facility's Clinical - Assessment list dated 10/07/2024 for Resident 23 revealed a Nursing Bedside Recliner Chair Assessment had been completed on 03/30/2024 and on 06/29/2024 but did not reveal a Nursing Bedside Recliner Chair Assessment had been completed for September 2024 or following the falls from a power recliner on 08/27/2024, 09/24/2024, or 10/02/2024.</p> <p>An observation on 10/02/2024 at 7:50 AM revealed Resident 23 was sleeping in the power recliner with the legs up and leaning to the right. The power recliner remote was not in reach and was laying on the floor.</p> <p>An observation on 10/02/2024 at 2:24 PM revealed Resident 23 was sleeping in the power recliner with the legs up, but the resident was sliding down with the feet off the end to mid-calf. The power recliner remote was not in reach and was laying on the floor.</p> <p>An observation on 10/07/2024 at 1:31 PM revealed Resident 23 was sleeping in the power recliner with the feet elevated and the power recliner remote was on the arm of the chair and the cord was tied to the upper right-hand side of the chair.</p> <p>An observation on 10/07/2024 at 3:50 PM revealed Resident 23 was awake and reclined in the power recliner with the feet elevated and the power recliner remote was in the pouch on the bottom of the right-hand side of the chair and the cord was tied to the upper right-hand side of the chair.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/08/2024 at 2:37 PM, NA-G confirmed NA-G was not working at the time of any of Resident 23's falls. NA-G confirmed the resident played with the power recliner remote and had previously slid out of the recliner. NA-G was not aware of any Care Plan interventions to prevent it from happening but did confirm to prevent it from happening, NA-G puts the controller in the pocket on the side of the recliner.</p> <p>In an interview on 10/08/2024 at 2:37 PM, NA-H confirmed NA-H was not working at the time of any of Resident 23's falls. NA-H confirmed the resident played with the power recliner remote and had previously slid out of the recliner. NA-G was not aware of any Care Plan interventions to prevent this from happening again.</p> <p>In an interview on 10/08/2024 at 9:51 AM, Resident 23's family member/Power of Attorney (POA) confirmed the POA was concerned that the resident was lifting the recliner all the way up and was being found on the floor. The family member/POA confirmed the resident needed the recliner for keeping the legs elevated and because the resident had sleep apnea and refused treatment. The family member/POA confirmed staff had not educated the family on the risk versus benefits of the power recliner and was upset due to the facility did not notify the family of the resident's fall on 10/02/2024, they were only notified of the fall in the bath house and 1 of the falls from the power recliner.</p> <p>In an interview on 10/08/2024 at 2:15 PM the facility's Clinical Nurse Consultant (CN) confirmed that the facility should have completed new Recliner Chair Assessments following each of Resident 23's falls from the power recliner to evaluate safety, but they were not completed. The CN confirmed that interventions should have been added to the Care Plan following the 09/24/2024 and 10/02/2024 falls from the recliner, but they had not been.</p> <p>42861</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641</p> <p>Licensure Reference Number 175 NAC 12-006.09</p> <p>Based on interview and record review, the facility failed to ensure rationale was provided and the provider's order was followed for 1 (Resident 26) of 5 sampled resident's as needed (PRN) Lorazepam (an antianxiety medication used to treat anxiety). The facility census was 47.</p> <p>Findings are:</p> <p>A record review of the facility's Medication Regimen Review (MRR) policy with a reviewed date 01/2024 revealed the pharmacist must report any irregularities to the attending physician, the facility's medical director, and the director of nursing (DON) and the reports must be acted on. Upon completion of the MRR, the facility designee and/or physician will respond to the recommendations in a timely manner. PRN orders for psychotropic drugs (substance that affect how the brain works) are limited to 14 days unless the attending physician believes that it is appropriate for the PRN order to be extended beyond 14 days, then they should document their rationale in the resident's medical record and indicate the duration for the PRN order.</p> <p>A record review of Resident 26's Clinical Census dated 10/03/2024 revealed the resident was admitted to the facility on [DATE].</p> <p>A record review of Resident 26's Medical Diagnosis dated 09/04/2024 revealed the resident had diagnoses of Restlessness and Agitation, Depression, and Psychotic Disorder (severe mental illness that causes a person to lose touch with reality).</p> <p>A record review of Resident 26's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to develop a resident's care plan) dated 07/16/2024 revealed the resident had a Brief Interview for Mental Status (BIMS, a score of a residents cognitive abilities) score of 15 out of of 15 which indicated the resident was cognitively aware. The MDS did not reveal the resident had behaviors during the assessment period. Anxiety was not listed in the MDS for the resident's mood disorders but the resident was on an antianxiety medication.</p> <p>A record review of Resident 26's Care Plan with an admitted [DATE] revealed the resident had a potential psychosocial (interrelation of social factors and thought and behavior) well-being problem related to the need for admission and possible need for long term care, but no specific interventions for the use of an antianxiety medication.</p> <p>A record review of the facility's pharmacy Admission Medication Regimen Review dated 07/15/2024 for Resident 26 revealed the pharmacist marked that the resident had a PRN psychotropic medication which will discontinue (DC) in 14 days, if physician does not want to DC in 14 days, please provide both rational and duration for the continued use of Lorazepam. The Nurse Practitioner ordered: indication anxiety times (x) 30 day then re-evaluate use.</p> <p>(continued on next page)</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A record review of the facility's pharmacy Pharmacist Recommendation to Prescriber dated 08/27/2024 for Resident 26 revealed a recommendation to DC the Lorazepam or if denied, the physician was to provide a clinical rationale for need and a date for reassessment was needed. There was no evidence of the physician having addressed the recommendation.</p> <p>A record review of Resident 26's Order Summary Report dated 10/03/2024 revealed the resident had an order for Lorazepam tablet 0.5 milligrams (MG) by mouth twice daily as needed for anxiety. The indications for use were anxiety/agitation. The order start date was 07/10/2024 and no stop date was listed.</p> <p>In an interview on 10/03/2024 at 12:46 AM, the facility's Clinical Nurse Consultant (CN) confirmed when the Nurse Practitioner ordered: indication anxiety times (x) 30 day the re-evaluate use on the Admission Medication Regimen Review dated 07/15/2024, the indication of anxiety was not a valid rationale to continue the Lorazepam for 30 days.</p> <p>In an interview on 10/03/2024 at 2:53 PM, the CN confirmed the rationale to continue the PRN Lorazepam for Resident 26 was not provided by the Nurse Practitioner, that the diagnosis was not a rationale, and the PRN Lorazepam was not stopped or re-evaluated in 30 days as ordered. The CN also confirmed that the Lorazepam was still ordered as PRN and should not have been.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>50683</p> <p>Licensure Reference Number 175 NAC 12-006.11(E)</p> <p>Based on observation, interview and record review; the facility failed to maintain the cleanliness of the kitchen to prevent the potential for food-borne illness and failed to ensure fluids were provided that were maintained within the required temperature range. This had the potential to affect all 47 residents that ate food prepared in the facility kitchen. The facility census was 47.</p> <p>Findings are:</p> <p>A.</p> <p>Record review of the Nebraska Food Code dated 2017. Section 4-602.13 revealed that nonfood- contact surfaces of equipment shall be cleaned at a frequency necessary to prevent the accumulation of soil residues.</p> <p>An observation of the facility kitchen on 10/02/2024 between 7:35 AM and 8:10 AM revealed the following environmental concerns:</p> <ul style="list-style-type: none"> -A ceiling exhaust fan, located directly above the walkway between the facility stove and food prep table, was coated with a fuzzy dark gray/black substance. Food was being prepared in this area and the exhaust fan was turned on. -Ceiling light panels near the facility stove and food preparation area were coated with multiple specks of a dark gray/black substance. -Exhaust fans located in the dry storage room were coated with a dark gray/black substance. -Food debris was observed on the bottom shelf of the freezer in the dry storage room. -Two white bins (resembling large trash cans) on a mobile base in the dry storage room contained food debris inside the bins and the mobile base was coated with a dark gray, thick and shiny substance. -A 6-shelved storage rack located in the kitchen near the dry storage room door had multiple staff personal items on the top shelf that included a box of Kleenex, 3 drink Koozies, a small metal tin labeled herbal healing salve, toothpicks, and an open can of Sprite. The shelves on this storage rack had visible food debris on all shelves and were coated with a sticky/greasy substance. -A wheeled cart with 3 shelves that had an attached can opener on the top shelf was coated with visible food debris and was coated with a brown, thick and shiny substance. -The floor in the dishwashing area (clean side) was coated with a dark gray substance around the base tiles and in the corners. <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An interview with DM on 10-2-2024 at 10:35 AM confirmed all items identified above were not clean and had the potential to cause food borne illness if any of the food debris or dark gray/black substance were to drop down into the food. DM confirmed that they were unsure when the last time the ceiling exhaust fan near the stove was cleaned. DM confirmed that all 47 residents that resided in the facility ate food that was prepared in the facility kitchen.</p> <p>B.</p> <p>Record review of facility policy Food Safety requirements dated/revised: May 2022 and January 2024 revealed It is the policy of this facility to provide safe and sanitary storage, handling, and consumption of all foods including those brought to residents by family and other visitors. This policy identified a definition of Danger Zone meant temperatures above 41 degrees Fahrenheit (F) and below 135 degrees F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness.</p> <p>An observation on 10-3-2024 at 12:27 PM revealed lunch was being served to the facility residents by the Cook. The lunch meal consisted of Swiss steak with gravy, mashed potatoes, cascade blend vegetables, toffee bar blondie (dessert bar), milk, tomato juice, iced tea, and coffee. During the observation a test tray was requested to be prepared and provided with room trays for residents who ate in their rooms.</p> <p>An observation on 10-3-2024 at 12:45 PM revealed the Dietary Manager (DM) obtained a facility thermometer and followed the room trays out the kitchen. Once the final resident room tray was delivered, the test tray was removed from the cart at 1:04 PM and DM obtained the temperature of the fluids and reported their findings with the following results:</p> <p>-White milk temperature was 60 degrees. DM reported that the temperature of the milk was concerning and refused to taste test.</p> <p>-Tomato Juice temperature was 62 degrees. DM reported that the temperature of the tomato juice was concerning and refused to taste test.</p> <p>-Iced tea temperature was 61 degrees. DM reported that ice should still be in the tea and that tea should be cold instead of room temperature.</p> <p>Interview with DM on 10-3-2024 at 1:15 PM confirmed that the temperatures of the milk and tomato juice were not cold enough and should not have been served to the residents.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45641</p> <p>Licensure Reference Number 175 NAC 12-006.19(C)(i)</p> <p>Licensure Reference Number 175 NAC 12-006.18(B)</p> <p>Based on observation, interview, and record review, the facility failed to ensure staff handled contaminated and clean laundry and linens to prevent cross contamination, failed to ensure Enhanced Barrier Precautions (EBP) signage was posted and Personal Protective Equipment (PPE) was available for staff use in 3 (Residents 23, 31, and 40) of 4 sampled resident's rooms, failed to ensure 1 (Resident 5) of 2 sampled resident's Positive Airway Pressure (PAP, a machine use to treat sleep apnea) device contained a filter, and failed to clean and store PAP supplies for 1 (Resident 2) of 2 sampled residents. The facility census was 47.</p> <p>Findings are:</p> <p>A.</p> <p>A record review of the facility's Standard Precautions policy with a last revised date of 01/2024 revealed soiled linens are handled in a manner that prevents contamination of clothing and avoids transfer of microorganisms (small germs) to other residents in the facility. Clean linen requires staff handle, store, process, and transport all linens and laundry in accordance with accepted national standards in order to produce hygienically (clean and free from bacteria) clean laundry and prevent the spread of infection to the extent possible. Linen should be covered when transporting and/or bagged so as not to come in contact with the staff's uniform.</p> <p>A record review of the facility's Laundry policy with a last revised date of 01/2024 revealed all used laundry was handled as potentially contaminated until it is properly bagged and labeled for appropriate processing. Contaminated laundry is placed in a bag or container at the location where it was used. Contaminated laundry bags/containers are not held close to body or squeezed during transport.</p> <p>An observation on 10/07/2024 at 8:36 AM revealed Nursing Assistant (NA)-A walked from the utility room and down the Garden Walk resident hallway with linens between NA-A's left arm and chest with the linens touching NA-A's clothing and entered a resident room.</p> <p>An observation on 10/07/2024 at 8:43 AM revealed Housekeeping Aide (HSK)-B obtained linens from the Serenity Lane linen closet and delivered the linens to room [ROOM NUMBER] and then to room [ROOM NUMBER] while carrying the linens between HSK-B's left arm and chest with the linens touching HSK-B's clothing.</p> <p>An observation on 10/07/2024 at 8:51 AM revealed HSK-B exit a resident room on Serenity Lane and walk to the laundry room with soiled linens held between HSK-B's arm and chest, touching HSK-B's clothing. The soiled linens were not bagged. HSK-B then obtained 2 leak chux pads (pads used to protect bedding and furniture from accidents or spills) and delivered then to resident room [ROOM NUMBER], allowing the chux pads to touch HSK-B's clothing during the transport.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>An observation on 10/07/2024 at 9:32 AM revealed the Environmental Services Director (ESD) delivered hanging laundry to resident room [ROOM NUMBER] while allowing the clothing to drag on and touch the floor and the ESD's clothing. The ESD then returned to the clean laundry cart and delivered hanging clothes to resident room [ROOM NUMBER] allowing the clothing to drag on the floor and touch ESD's clothing. The ESD returned to the clean laundry cart and held a blanket between their left arm and chest, against the ESD's clothing, and delivered to resident room [ROOM NUMBER]. The ESD then returned to the cart and delivered hanging clothes to resident rooms [ROOM NUMBERS] while allowing the clean clothing to touch the ESD's clothing. The ESD then delivered clean laundry to resident rooms [ROOM NUMBERS] and allowed the residents' clothing to come in contact with the ESD's clothing. The ESD then continued delivering clothing in that same manner to the rest of the residents' rooms.</p> <p>An observation on 10/07/2024 at 9:35 AM revealed NA-C left the residents' bath house with clean linens pressed between NA-C's arm and clothing and delivered the linens to resident room [ROOM NUMBER].</p> <p>An observation on 10/07/2024 at 9:50 AM with the Director of Nursing revealed the facility's ESD delivered clean clothing to residents room [ROOM NUMBER] while allowing the clean clothing to come into contact with ESD's clothing.</p> <p>In an interview on 10/07/2024 at 9:50 AM, the DON confirmed the staff should not allow clean or contaminated laundry or linens to come into contact with the staff's clothing.</p> <p>B.</p> <p>A record review of the facility's Infection Prevention and Control Program policy with a revised date of 01/2024 revealed laundry and direct care staff shall handle, store, process, and transport linens so as to prevent the spread of infection. Clean linen shall be delivered to resident care units on covered linen carts with the covers down.</p> <p>An observation on 10/07/2024 at 9:32 AM revealed the ESD exited the laundry room and delivered the laundry cart down the Garden Walk resident hallway with the cart's side cover draped over the cart and laundry on top of the cart.</p> <p>An observation on 10/07/2024 at 9:50 AM with the Director of Nursing (DON) revealed the ESD delivered the laundry cart down the Garden Walk hallway with the side cover draped over top of the cart.</p> <p>In an interview on 10/07/2024 at 9:50 AM, the DON confirmed the staff laundry carts should have all covers down when transported in resident care areas.</p> <p>C.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>A record review of the facility's Multi Drug Resistant Organism (MDRO) PPE-Enhanced Barrier policy with a last revised date of 01/2024 revealed EBP's are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high-contact resident care activities. EBP may be indicated for residents with wounds or indwelling medical devices (devices inserted into the body), regardless of MDRO colonization (a group of MDRO germs living in or on the body) status. Indwelling medical device examples included urinary catheters. The facility should post clear signage on the door or wall outside the resident's room indicating the type of precautions and the required PPE. For EBP, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. Gown and gloves should be available outside each resident room.</p> <p>A record review of the facility's un-titled, un-dated resident matrix (a list of problem areas a resident had) revealed Residents 23, 31, and 40 had indwelling catheters but did not reveal the residents were in transmission-based precautions (isolation).</p> <p>A record review of Resident 23's Clinical Physician Orders dated 10/07/2024 revealed the resident had orders to change their indwelling urinary catheter every month and for catheter cares to be done every 12 hours.</p> <p>A record review of Resident 23's Care Plan with an admitted [DATE] revealed the resident had a Suprapubic (SP) catheter (drain tube inserted in the urinary bladder).</p> <p>A record review of Resident 23's Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to develop a resident's care plan) dated 07/23/2024 revealed the resident had an indwelling catheter.</p> <p>A record review of Resident 31's Clinical Physician Orders dated 10/07/2024 revealed the resident had orders to measure catheter output every shift and to provide catheter cares every shift.</p> <p>A record review of Resident 31's Care Plan with an admitted [DATE] revealed the resident had a foley catheter (drain tube inserted in the urinary bladder).</p> <p>A record review of Resident 40's Clinical Physician Orders dated 10/07/2024 revealed the resident had orders to measure catheter output every shift and to provide catheter cares every shift.</p> <p>A record review of Resident 40's Care Plan with an admitted [DATE] revealed the resident had a foley catheter.</p> <p>A record review of Resident 40's MDS dated [DATE] revealed the resident had an indwelling catheter.</p> <p>An observation on 10/07/2024 at 9:58 AM with Licensed Practical Nurse (LPN)-E revealed Resident 23 had a visible catheter bag.</p> <p>An observation on 10/07/2024 at 2:16 PM revealed Residents 23, 31, and 40 all had visible catheter bags but did not reveal EBP signage or PPE carts outside their rooms.</p> <p>An observation on 10/07/24 at 2:19 PM with the DON revealed Residents 23, 31, and 40 all had visible catheter bags but did not reveal EBP signage or PPE carts outside their rooms.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>In an interview on 10/07/2024 at 9:58 AM, LPN-E confirmed Resident 23 had an indwelling urinary catheter but did not have an EBP sign or PPE cart outside their rooms and should have.</p> <p>In an interview on 10/07/24 at 2:19 PM the DON confirmed Residents 23, 31, and 40 all had indwelling catheters but did not have EBP signage or PPE available outside their rooms and should have.</p> <p>D.</p> <p>A record review of the facility's Cleaning Respiratory Equipment policy dated 05/01/2017 revealed the facility was committed to providing a safe and healthy environment for residents and to minimize or prevent the spread of infections. The staff was to change filters used with a PAP circuit per manufacturer's recommendations.</p> <p>A record review of the undated ResMed AirSense 10 Users Guide revealed the air filter should be replaced at least every 6 months and more often if needed. https://document.resmed.com/documents/products/machine/airsense-series/user-guide/airsense-10-device-with-humidifier_user-guide_amer_eng.pdf</p> <p>A record review of Resident 5's Treatment Administration Record (TAR) dated September 2024 and October 2024 revealed the resident's PAP filter was last changed/replaced on 09/25/2024.</p> <p>An observation on 10/02/2024 at 11:57 AM revealed Resident 5 had a ResMed AirSense 10 Autoset Continuous Positive Airway Pressure (CPAP), but the unit did not have a filter.</p> <p>An observation on 10/03/2024 at 11:35 AM revealed Resident 5 had a ResMed AirSense 10 Autoset CPAP, but the unit did not have a filter.</p> <p>An observation on 10/07/2024 at 8:21 AM revealed Resident 5 had a ResMed AirSense 10 Autoset CPAP, but the unit did not have a filter.</p> <p>An observation on 10/07/2024 at 8:40 AM with LPN-F revealed Resident 5 had a ResMed AirSense 10 Autoset CPAP, but the unit did not have a filter.</p> <p>In an interview on 10/07/2024 at 8:40 AM, LPN-F confirmed Resident 5's CPAP did not have a filter and should have had one.</p> <p>42861</p> <p>E.</p> <p>A record review of the facility policy titled Cleaning Respiratory Equipment, dated 5/1/2017 read as follows;</p> <p>Procedure</p> <p>1.Supplies:</p> <p>- Replace masks and/or cannula used by an individual resident within seven days.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285164	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/08/2024
NAME OF PROVIDER OR SUPPLIER Holmes Lake Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>- When not in use, store masks and cannulas in plastic bags labeled with the resident's name and date.</p> <p>A record review of the document titled Admission Record revealed Resident 2 had been admitted to the facility on [DATE] with a primary diagnosis of dementia (general term that represents a group of diseases and illnesses that affect your thinking, memory, reasoning, personality, mood and behavior) with behavioral disturbances.</p> <p>A record review of the Minimum Data Set (MDS, a federally mandated comprehensive assessment of each resident's physical and mental functional capabilities) dated 8/2/24 revealed that Resident 2 had a Brief Interview for Mental Status (BIMS, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function, while scores of 00 or 99 indicate total confusion) score of 9, which indicated the resident had moderately impaired cognition.</p> <p>An observation on 10/02/24 at 8:05 AM revealed Resident 2's Continuous Positive Airway Pressure (CPAP, a treatment that uses mild air pressure to keep your breathing airways open) mask to be attached to undated tubing that was attached to the CPAP machine and the mask was lying uncovered on the floor next to the head of the resident's bed.</p> <p>An observation on 10/03/24 at 10:03 AM revealed Resident 2's CPAP mask to be attached to undated tubing that was attached to the CPAP machine while draped over the 3-drawer cart next to the resident's nightstand with the face side of the mask touching the cart.</p> <p>An interview on 10/03/24 at 10:10 AM with LPN-E, after observing Resident 2's CPAP mask attached to the tubing and machine and draped over the 3-drawer cart, confirmed that the CPAP masks were to be stored in a bag and confirmed that Resident 2's CPAP mask was not being cleaned and stored to prevent the potential for cross contamination.</p>		

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NAME OF PROVIDER OR SUPPLIER Holmes Lake Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 6101 Normal Blvd Lincoln, NE 68506	
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<p>F 0947</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>42861</p> <p>Licensure Reference Number 175 NAC 12-006.04(B)(ii)(1)</p> <p>Based on record review and interview; the facility failed to ensure current staff were completing the required 12 hours of continuing education annually. This had the potential to affect all residents in the facility. The facility identified a census of 47.</p> <p>Findings are:</p> <p>A record review of the facility policy titled Required Training, Certification and Continuing Education of Nurse Aides, dated 11-17; 1-2024 revealed the following guidelines;</p> <p>It is the policy of this facility too comply with State and Federal regulations and requirements as they pertain to the training, certification, and continuing educate of its nurse aides. 5. The facility will provide at least 12 hours of in-service training annually, based on the employment date, not calendar year. a. Documentation of in-services will be forwarded to the HR Director and maintained in the employee's personnel file.</p> <p>An interview on 10/07/24 at 2:40 PM with the facility's Corporate Nurse Consultant confirmed that NA-O hired on 3/4/22, NA-G hired on 6/30/22, MA-P hired on 6/22/09 and MA-Q hired on 2/16/18 had not completed 12 hours of continuing education annually as completed required. The facility Corporate Nurse Consultant also confirmed that the only education that these 4 staff members had completed in the last one year was an Abuse and Neglect training.</p>		