STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285165	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Platte Care Center, LLC	2900 West E Street North Platte, NE 69101

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 49766 Licensure Reference Number 175 NAC 12-006.09D5b Based on observations, interviews, and record review, the facility failed to provide activities of choice to 1 (Resident 9) of 1 sampled residents. The facility identified a census of 60. The findings are: A record review of Resident 9's Medical Diagnosis revealed the facility had admitted Resident 9 on 10/12/2019 with diagnoses of: major depressive disorder, Dementia, chronic obstructive pulmonary disease, insomnia, retention of urine, and constipation. A record review of Resident 9's significant change Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), dated 2/26/2024, revealed Resident 9 had a Brief Interview for Mental Status (BIMS) score of 15/15, which revealed the resident was cognitively intact. The MDS also indicated Resident 9's activity preference for doing things with groups of people was very important and doing Resident 9's activity preference for doing favorite activities and going outside was somewhat important. A record review of Resident 9's Care Plan revealed an intervention to establish Resident 9's interest by talking with the resident. It also included an intervention of resident's preferred activities are watching television, reading magazines, and sitting outside when weather is nice. An observation on 3/18/2024 at 1:16 PM revealed Resident 9 had been resting in their bed staring at the wall without activity. An observation on 3/19/2024 at 12:50 PM revealed Resident 9 had been sitting in their wheelchair without activity, awaiting transportation to an appointment at 1:45 PM. An observation on 3/21/2024 at 9:58 AM revealed Resident 9 had been resting in bed without activity. Resident 9 had begun to get tearful when discussing desire to go out of the facility for activities. (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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/18/2024 at 1:16 PM with Resident 9 revealed [gender] did not participate in activities due to having no interest in provided activities. The interview also revealed Resident 9 likes to play card games, but facility is not able to offer this due to no other residents being interested. Resident 9 denied activities staff offering to play card games with Resident 9. An interview on 3/19/2024 at 8:45 AM with Resident 9 revealed other activity interests of card games, rodeos, and outdoor activities. Resident 9 had tearfully stated but none of that is a choice. Once they locked me down, they locked me down for good. An interview on 3/19/2024 at 12:34 PM with Registered Nurse (RN)-B revealed Resident 9 had been self-isolating in room since December and had not attended activities or come out of room to chat with staff. An interview on 3/21/2024 at 10:16 AM with the Activities Supervisor (AS) confirmed Resident 9 had a decrease in activity participation and previously liked to watch television and attend music activities. The AS revealed [gender] had not done any activities with Resident 9 besides working on a shopping list. The AS also confirmed options to seek out activities in the community if the resident chose to. An interview on 3/21/2024 at 10:38 AM with Director of Nursing (DON) revealed they were unaware of Resident 9's decrease of participation in activities. The DON stated an intervention was attempting to get Resident 9 up in their wheelchair inside their room for meals. A record review of Resident 9's Progress Notes from 11/1/2023 through 3/18/2024 revealed two notes of documentation of activities had occurred for Resident 9. On 3/18/2024 a late entry was documented the AS had made a grocery list with Resident 9 and had gone shopping for Resident 9. On 11/1/2023, a note was documented the AS had went shopping for Resident 9. The record review revealed no other activities had been offered or completed from 11/1/2023 through 3/18/2024.

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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** 49263 Licensure Reference Number 175 NAC 12-006.09 Based on record review and interviews, the facility failed to follow physician's orders regarding daily weights for 1 (Resident 36) of 1 sampled resident. The facility census was 60. The Findings Are: A record review of Resident 36's admission record revealed the resident was admitted to the facility on [DATE] with a primary diagnosis of pneumonia, unspecified organism. A record review of Resident 36's undated Care Plan revealed the resident had a diagnosis of congestive heart failure and had an intervention in place for weight monitoring. A record review of Resident 36's Physician's Orders revealed an order for daily weights to be obtained on the day shift related to their diagnosis of Unspecified Diastolic (Congestive) Heart Failure. The order also stated to give PRN (as needed) Lasix if the resident had a weight gain of 4 to 5 pounds, and to call the Primary Care Provider (PCP). The start date for this order was 12/21/2023. A record review of Resident 36's Physician's Orders revealed orders for furosemide (Lasix) 20 milligrams (MG) to be given every other day and an order for furosemide (Lasix) 40 MG to be given every other day, on opposing days from the 20 MG order. There was no evidence of a current order for PRN Lasix to be given. A record review of Resident 36's Treatment Administration Record (TAR) for February 2024 revealed the resident's order for a daily weight to be obtained on the day shift had no documentation on February 5th, 10th, or 29th. There was a staff initial and an x, but no weight documented on February 12th -17th, and on the 23rd. A record review of Resident 36's TAR for March 2024 revealed the resident's order for a daily weight to be obtained on the day shift had no documentation on March 1st, 7th, 8th, 9th, 11th, 14th, or on the 18th. A record review of Resident 36's Vital Signs section of their electronic health record (EHR) revealed no weight recorded for February 2nd-5th, 7th, 9th-10th, 12th-19th, 21st-23rd, 27th-28th, 2024 There were also no weights recorded for March 1st, 3rd, 7th, 9th-11th, 13th, 15th-16th, 18th, or 20th, 2024. A record review of Resident 36's EHR revealed the resident was hospitalized and not available for the facility to obtain daily weights February 12th-18th, 2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/21/24 at 12:40 PM with the Director of Nursing (DON) confirmed the daily weight order did state to give PRN Lasix with a weight gain of 4 to 5 pounds. The DON also confirmed the resident did not have a current order for PRN Lasix. The DON confirmed the PRN Lasix order was discontinued by the pharmacist upon the resident's return to the facility from the hospital on 2/18/24 per the transition orders received from the doctor but the daily weight order was not updated at that time to reflect the change. An interview on 3/21/24 at 12:50 PM with the Administrator confirmed there were no additional weights obtained for Resident 36 other than the weights recorded in the resident's EHR as the administrator was the staff responsible for adding the weights obtained by staff to the EHR.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 49766 Licensure Reference Number 175 NAC 12-006.09D2b Based on observations, interviews, and record review, the facility failed to provide treatment of a pressure ulcer for 1 (Resident 9) of 4 sampled residents. The facility identified a census of 60. The findings are: A record review of Resident 9's Medical Diagnosis revealed the facility had admitted Resident 9 on 10/12/2019 with diagnoses of: major depressive disorder, Dementia, chronic obstructive pulmonary disease, and Diabetes Mellitus. A record review of Resident 9's significant change Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 2/26/2024, revealed Resident 9 had a Brief Interview for Mental Status (BIMS) score of 15/15, which revealed the resident was cognitively intact. The MDS also indicated Resident 9 was at risk for pressure ulcers with a pressure ulcer present. A record review of Resident 9's Weekly Skin Assessment with a date of 3/5/2024 revealed Resident 9 had an unstageable pressure sore to the right great toe. A record review of Resident 9's Care Plan revealed an intervention and treatment per the physician's order for a pressure wound of the right great toe. The Care Plan identified to follow the facility's policy for wound treatment. A record review of Resident 9's Physician Orders revealed an order with a date of 3/5/2024 to complete a wound dressing to the right great toe with betadine and cover with band aid daily. An interview on 3/20/2024 at 8:25 AM with Resident 9 revealed Resident 9 was not aware of the pressure ulcer. Resident 9 had stated I never knew anything about it until yesterday when you asked about watching it be changed. A record review of Resident 9's Treatment Administration Record (TAR) revealed the treatment was not documented on 3/7/2024, 3/8/2024, 3/16/2024, and 3/19/2024. An observation on 3/20/2024 at 12:25 PM revealed no band aid covering from 3/19/2024 in place on Resident 9's right great toe as per order. An interview on 3/20/2024 at 12:25 PM with Registered Nurse (RN) - B confirmed there was no band aid covering in place on Resident 9's right great toe. RN-B confirmed treatment of Resident 9's pressure ulcer included frequent monitoring to ensure dressing was intact and completing daily treatments. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/21/2024 at 9:05 AM with the Director of Nursing (DON) confirmed the TAR was missing documentation from 3/7/2024, 3/8/2024, 3/16/2024 and 3/19/2024. The DON denied having additional documentation that the treatment had been completed with confirming statement if it was not documented, it was not done. A record review of the facility's Skin Care and Wound Management policy, with a date of 6/2015, under section Procedure read to conduct daily round to verify that appropriate wound treatment protocols are followed and documented. A record review of the facility's Skin Care and Wound Management policy, with a date of 6/2015, under section Treatment read to document treatment protocols on the TAR.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.09D6 (7) Based on observation, record review and interview; the facility staff failed to change oxygen tubing for 2 (Resident 10 and 49) of 2 sampled residents and failed to change the nebulizer mask with tubing for 1 (Resident 49) of 1 sampled resident which had the potential to cause infection. The facility census was 60. Findings are: A. A record review of Resident 10's Medical Diagnosis printed 3/18/2024 revealed Resident 10 was readmitted to the facility on [DATE] with diagnoses of: congestive heart failure (CHF-the heart does not pump blood as well as it should), obstructive sleep apnea (intermittent airflow blockage during sleep), morbid obesity, pulmonary hypertension (a type of high blood pressure that affects the arteries in the lungs and the right side of the heart), paranoid schizophrenia (a mental disorder in which the person has irrational thoughts, delusions and hallucinations). A record review of Resident 10's Clinical Physician Orders printed 3/18/2024 revealed an order for oxygen to be worn at 3 liters per minute via BiPap (non-invasive ventilation which helps you breathe through a mask) machine at bedtime. A record review of Resident 10's Treatment Administration Record (TAR-a legal and accurate record of the treatments received by the resident) dated 1/2024 revealed an order to change oxygen tubing on the first of the month and was documented to have been changed on 1/1/2024. A record review of Resident 10's TAR dated 2/2024 revealed an order to change oxygen tubing on the first of the month and was documented to have been changed on 2/1/2024. A record review of Resident 10's TAR dated 3/2024 revealed a order to change oxygen tubing on the first of the month and was documented to have been changed on 3/1/2024. A record review of Resident 10's TAR dated 3/2024 revealed a new order as of 3/4/2024 to change oxygen tubing every week on Monday and this was documented to have been done on 3/4/2024 and 3/11/2024. An observation on 3/18/2024, 3/19/2024, and 3/20/24 of Resident 10's oxygen tubing which was attached to her oxygen concentrator (a machine that purifies the surrounding air and is distributed through a nasal cannula or a mask to the resident) and BiPap machine revealed a date of 1/1/2024. An observation and interview on 3/20/2024 at 11:00 AM with RN-B (Registered Nurse) revealed the tubing was dated 1/1/2024 and is overdue to be changed and is to be changed weekly as of 3/4/2024 and was not. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/20/2024 at 12:10 PM with the DON (Director of Nursing) confirmed that the oxygen tubing dated 1/1/2024 is outdated and should have been changed per the orders and was not. B. A record review of Resident 49's Medical Diagnosis printed 3/18/2024 revealed Resident 49 was readmitted to the facility on [DATE] with diagnoses of: chronic congestive heart failure (CHF), chronic kidney disease, Stage 4 (disease in which kidneys are moderately or severely damaged and not working as well as they should to filter waste from your blood), anemia (the blood does not have enough healthy red blood cells and hemoglobin which carries oxygen throughout the body), morbid obesity, major depressive disorder (persistent feeling of sadness or lost of interest). A record review of Resident 49's Medication Administration Record (MAR-a legal and accurate record of the medications received by the resident) dated 1/2024 revealed an order for Formoterol (liquid medicine used to treat lung problems) 1 vial per twin jet nebulizer (TJN-a machine that turns liquid medicine into a mist that is inhaled) every 12 hours and was documented to have been given the month of January 2024. There was also an order for Albuterol (a liquid medication that helps open the airways in the lungs) 1 vial per TJN four times a day as needed for wheezing which was documented to have been given twice on 1/9/2024, twice on 1/17/2024 and once on 1/22/2024. There is also an order for oxygen to be worn at 2 liters per minute via nasal cannula to be worn continuously to keep oxygen saturation above 90% which was documented to have been worn the month of January 2024. A record review of Resident 49's TAR dated 1/2024 revealed an order for oxygen cannula/mask/tubing to be changed on the first of the month. This was documented to have been done on 1/1/2024. There is also an order to change oxygen nebulizer mask and tubing every week which was documented to have been done on 1/6/2024, 1/13/2024, 1/20/2024, and 1/27/2024. A record review of Resident 49's MAR dated 2/2024 revealed an order for formoterol 1 vial per twin jet nebulizer every 12 hours and was documented to have been given the month of February 2024. There was also an order for Albuterol 1 vial four times a day as needed for wheezing which was documented to have been given on 2/11/2024 and 2/17/2024. There is also an order for oxygen to be worn at 2 liters per minute via nasal cannula to be worn continuously to keep oxygen saturation above 90% which was documented to have been worn the month of February 2024. A record review of Resident 49's TAR dated 2/2024 revealed an order to change oxygen cannula/mask/tubing every month on the first of the month which was documented to have been done on 2/1/2024. A new order received 2/19/2024 stated to change oxygen cannula/mask/tubing every week on Monday. This was documented to have been done 2/19/2024 and 2/26/2024. There is also an order to change the oxygen nebulizer mask and tubing weekly on Saturday and this was documented to have been done 2/3/2024, 2/10/2024, 2/17/2024, and 2/24/2024. A record review of Resident 49's MAR dated 3/2024 revealed an order for Albuterol 1 vial per twin jet nebulizer four times a day as needed for wheezing and was discontinued on 3/12/2024 and had not been used the month of March 2024. There was also an order for Albuterol 1 vial four times a day as needed for wheezing which was discontinued on 3/12/2024 and had not been used the month of March 2024. There is also an order for oxygen to be worn at 2 liters per minute via nasal cannula to be worn continuously to keep oxygen saturation above 90% which was documented to have been worn the month of March 2024. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 49's TAR dated 3/2024 revealed an order to change oxygen cannula/mask/tubing weekly every Monday and was documented to have been done on 3/4/2024 and 3/11/2024. There was also an order to change the oxygen nebulizer mask and tubing weekly on Saturday which was not documented to have been done the month of March. An observation on 3/18/2024, 3/19/2024 and 3/21/2024 revealed the resident was on 3 liters per minute via nasal cannula and the oxygen tubing was not dated. The nebulizer mask and tubing were dated 2/24/2024. An observation on 3/20/2024 at 7:50 AM revealed the resident is lying in bed with nebulizer mask on face and running and mist is coming from the mask. An observation on 3/20/2024 at 8:30 AM the nebulizer machine is still running but the mask is sitting on the bed. An observation on 3/20/2024 at 9:20 AM the nebulizer mask is sitting upright on the nebulizer machine and is shut off. An interview and observation on 3/20/2024 at 10:50 with RN-B revealed that oxygen tubing and nebulizer masks are to be changed weekly. RN-B confirmed that the oxygen tubing the resident is using had no date and didn't know how old the tubing is, but needed to be changed. RN-B also confirmed that the nebulizer mask was dated 2/24/2024 and is overdue to be changed. RN-B also stated that the residents breathing treatments through the nebulizers had been discontinued 3/12/2024 and did not know who started her breathing treatment and shut it off this morning. An interview on 3/20/24 at 12:20 PM with the DON confirmed that Resident 49's oxygen tubing should have been dated and needs to be changed and the nebulizer mask is outdated and should have been changed. An observation on 3/21/2024 at 8:30 AM revealed in the resident's room a new oxygen tubing dated 3/20/2024 and the nebulizer machine was removed from the room since the medications for the nebulizer were discontinued 3/12/2024. A record review of the facility policy Oxygen Administration dated 6/15/2021 under procedure revealed: 7. Date disposable supplies upon opening. Change disposable equipment as indicated, refer to the Respiratory Equipment Change guide in this manual. A record review of the facility policy Respiratory Equipment Change Schedule dated 1/2013 revealed under the Purpose: routine cleaning and/or changing of disposable respiratory equipment is done to prevent nosocomial infections. Further review under Procedure revealed: 1. Observe the following change schedule for disposable items: Aerosol producing devices, such as nebulizers, IPPB circuits, continuous aerosol systems-weekly and prn. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxygen delivery devices (non-aerosol producing) Ex: venturi masks, nasal cannulas, oxygen supply tubing-weekly and prn. 2.Date all disposable supplies upon opening.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 49766 Licensure Reference Number 175 NAC 12-006.10 Based on interviews and record review, the facility failed to ensure an as needed antipsychotic medication was limited to 14 days and had a physician documented rationale for continuance. This affected 1 (Resident 114) of 6 sampled residents. The facility identified a census of 60. The findings are: A record review of Resident 114's Face Sheet revealed the facility admitted Resident 114 on 2/28/2024 with diagnoses of: altered mental status, adult failure to thrive, hallucinations, Dementia with moderate behavioral disturbance, and cognitive communication deficit. A record review of Resident 114's significant change Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents) dated 3/9/2024, revealed Resident 114 had a Brief Interview for Mental Status (BIMS) score of 4/15, which revealed the resident had severe cognitive impairment. The MDS also indicated Resident 114 had physical (hitting, kicking, grabbing, etc.) and verbal (threatening, screaming, cursing, etc.) behavioral symptoms 4 to 6 days of the week. The MDS revealed Resident 114 had behaviors of wandering which had occurred daily and rejection of care had occurred 1 to 3 days a week. A record review of Resident 114's orders included an order for quetiapine (an atypical antipsychotic medication used to treat schizophrenia, bipolar disorder and depression) 25 milligrams (mg) with directions to give 1 tablet orally every 8 hours as needed (PRN) for agitation. The order had begun on 3/5/2024 and did not include a stop date or duration. A record review of Resident 114's Physician Documentation with a date of 3/14/2024 included an order to continue the PRN quetiapine order without a clinical rationale. The order did not include a stop date or duration. An interview on 3/21/2024 at 9:04 AM with the Director of Nursing (DON) confirmed order for Resident 114's PRN quetiapine order began on 3/5/2024 and the medication was still being utilized as there had been no stop date or duration included on the order. An interview on 3/21/2024 at 9:15 AM with Registered Nurse (RN) - A confirmed Resident 114's PRN quetiapine order did not include a duration or stop date and the facility did not have a documented rationale from the physician to continue past 14 days. An interview on 3/21/2024 at 9:28 AM with the Administrator (ADM) revealed the facility does not have a policy for as needed psychiatric medication as the facility follows physicians' orders.

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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. 49380 Licensure Reference Number 175 NAC 12-006.11E Based on observation, record review and interviews, the facility failed to ensure food was labeled and dated to prevent the potential of food borne illness. This had the potential to affect all residents who consumed food from the kitchen. The facility census was 60. Findings are: A. An observation on March 18, 2024, at 10:45 AM during the initial walk through of the kitchen walk through revealed: - One open plastic bag of spaghetti with no listed expiration date or open date. The bag of spaghetti was within a box which also did not contain an opened or expiration date. - One open plastic bag of elbow macaroni with no expiration date or open date. The bag of elbow macaroni was within a box which also did not contain an opened or expiration date. - One open plastic bag of long grain rice with no expiration date or open date. The long grain rice was within a box which also did not contain an opened or expiration date. - One bottle of soy sauce was open without an opened date or expiration date. An observation on March 18, 2024, at 10:45 AM in the only walk-in fridge/freezer revealed: -One open plastic bag of tater tots which was sitting within a box with neither identifying the open or expiration date. An interview with Dietary Supervisor (DS) 03/18/24 at 10:45 AM revealed all food items are to be dated with an entry date upon arrival to the facility as well as with an open date. The DS revealed the expiration dates would be indiciated on the item by the manufacture. The DS confirmed the items listed above should have been marked with open dates and expiration dates. The DS revealed the facility does not have a policy on food storage.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285165	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
North Platte Care Center, LLC	2900 West E Street North Platte, NE 69101

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 49380 Licensure Reference Number 175 NAC 12.006.18A Based on observations and interviews, the facility failed to ensure garbage was stored in a manner to prevent harborage and feeding of pests by failing to ensure trash receptacles were covered and not open. This had the potential to affect all the facility's residents. The facility identified a census of 60 at the time of survey. An observation on March 18, 2024 at 10:45 AM of the facility outside of the back entry to the kitchen revealed the following: - 1 trash receptable which had the back of the receptable open with no coverings and trash was visible inside, - 1 trash receptable which had the front and the back of the receptable open with no coverings and trash was visible inside. Interview with Dietary superviosor (DS) on March 20, 2024, at 10:45 AM confirmed the lids the 2 trash receptables were uncovered with trash inside. The DS confirmed the facility had called the trash company but was unaware of a delivery date to replace the coverings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285165	A. Building B. Wing	03/21/2024

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49383 Licensure Reference Number 175 NAC 12-006.17D Based on observation, record review and interview; the facility failed to ensure hand hygiene was performed to prevent the spread of infection or prevent cross contamination during and after incontinence care with appropriate change of gloves for 1 (Resident 49) of 1 sampled resident. The facility census was 60. Findings are: An observation on 3/20/2024 at 11:00 AM of personal cares were completed on Resident 49 by NA-D (nursing assistant) and NA-F revealed the following: Resident 49 was lying on [gender] back in bed. NA-D performed hand hygiene (HH) with soap and water at the resident's sink for 20 seconds. NA-F performed HH for 30 seconds with soap and water at the sink. Both nursing assistants applied gloves and the privacy curtain was pulled. NA-D began to pull the covers down the resident. NA-F pulled the window blinds. NA-D undid the tabs on the incontinence brief and removed the pillow from under the resident's legs. NA-D then pulled multiple incontinence wipes from the package and set them on top of the package. NA-D then wiped the resident's catheter from insertion site down the catheter tubing with 4 separate wipes. NA-D then threw these dirty wipes away in the trash. NA-D then reached into the incontinence package for additional wipes. NA-D then washed around the resident's meatus (opening of the urethra) with wipes. NA-D then removed [gender] soiled gloves and performed HH at the sink with soap and water for 10 seconds. NA-D then applied new gloves. NA-D removed more incontinence wipes from the package. NA-D then washed the resident's groin and abdominal folds with separate wipes and threw the wipes away. NA-D removed her soiled gloves and immediately put new gloves on. Both nursing assistants then assisted the resident to her side. NA-D washed the resident's buttocks which were soiled with stool with incontinence wipes. NA-D then began to place a clean incontinence brief on the resident with the same gloves. NA-D picked up the incontinence wipe package and moved it to the bedside table. NA-D assisted the resident onto [gender] back. NA-D took the foley drain bag from NA-F and placed the drain bag on the bed frame. NA-D and NA-F repositioned the resident more to fix the brief. NA-D adjusted the residents clothing. The tabs on the brief were applied by both nursing assistants. NA-D removed [gender] soiled gloves and threw them away. NA-F removed [gender] soiled gloves and performed HH at the sink with soap and water for 25 seconds. NA-D began taking items out of the resident's wheelchair so that the resident could be transferred into the wheelchair. NA-D removed clothes from the wheelchair and folded blankets. NA-D then performed HH at the sink with soap and water for 5 seconds. An interview on 3/20/2024 at 11:20 AM with NA-D revealed that NA-D thought the handwashing policy called for 10 seconds of washing with soap and water. After reviewing the facility's handwashing policy, NA-D confirmed [gender] did not wash [gender] hands long enough. NA-D also revealed [gender] should have removed soiled gloves after use and immediately performed HH with soap and water for 20 seconds before touching clean surfaces. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285165	A. Building B. Wing	03/21/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 3/20/2024 at 12:10 PM with the DON confirmed that HH with soap and water is 20 seconds and confirmed that NA-D did not wash their hands long enough when performing morning cares. The DON also confirmed that HH should have been completed after removing soiled gloves before touching clean surfaces. A record review of the facility policy Hand Hygiene dated 3/2022 revealed: Healthcare providers must perform hand hygiene for the following: immediately before touching a resident or the resident's immediate environment, before performing an aseptic (free from contamination) task or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after contact with blood, body fluids, or contaminated surfaces, and immediately after glove removal. The procedure for soap and water: 1. Turn on water to desired temperature. 2. Wet hands with water 3. Apply soap to hands and begin to rub surfaces, working soap into a lather. 4. Continue to rub vigorously for 15 seconds. 5. Rinse your hands with water. 6. Thoroughly dry hands using a disposable paper towel. Procedure for glove use: 1. Gloves do not replace the need for hand hygiene. 2. If your task requires gloves, perform hand hygiene prior to donning gloves. 3. Change gloves and perform hand hygiene during patient care, if gloves become damaged, gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient. 4. Never wear the same pair of gloves in the care of more than one patient 5. Perform hand hygiene immediately after removing gloves. A record review of the CDC guidelines for handwashing recommends hands should be washed with soap and water vigorously for 20 seconds.