STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Kenesaw	100 West Elm Avenue Kenesaw, NE 68956

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. Based on interviews and record reviews, the facility failed to notify 1 resident in writing before the resident's room in the facility changed. This affected 1 of 1 sampled resident (Resident 32). The facility census was 67. Findings are:A record review of an electronic form titled, Census dated 8/21/2025 for Resident 42 revealed an admission date of 08/03/2023. The form further revealed Resident 42 had a room change entered on the census as of 08/20/2025. A record review of Resident 42's electronic medical record (EMR, digital collection of medical information about a person that is stored on a computer) titled Progress Notes revealed on 08/19/2025 an IDT note stating Resident 42 was being monitored for room change and new roommate, resident moved to a new room to prevent falls. The record also revealed on 08/20/2025 a Brief Interview for Mental Status (BIMS; a brief screener that aids in detecting cognitive impairment) score of 10/15. A score of 8-12: reveals a moderate impairment. On 08/20/2025 at 1:05 PM, Resident 42 was interviewed which revealed the facility had recently packed up their belongings and moved their items to another room. Resident 42 further revealed no knowledge of the move or reasoning for the move. The Social Services Director (SSD) was interviewed on 08/21/2025 at 11:00 AM. The SSD stated they were typically involved in room moves, however was not familiar on the room move for Resident 42. The SSD further revealed that the Director of Nursing (DON) was involved and could clarify details on Resident 42's room move. The DON was interviewed on 08/21/2025 at 11:26 AM. The DON stated they and the Interdisciplinary Team (IDT; a group of professionals from various healthcare disciplines who collaborate to provide comprehensive care to a patient) decided to move Resident 42 due to increased falls the resident was having. The DON was then interviewed about notifying Resident 42 on the room move request, to which the DON revealed Resident 42 was spoken to regarding reasons for the move and stated the resident had agreed to it, and the room move occurred on Monday 08/18/2025. The DON then revealed that Resident 42 was not alert and oriented to place or person and displays hallucinations, delusions and is unable to make those decisions. When asked if the Power of Attorney (POA; someone to make decisions on their behalf regarding finances or healthcare) was notified, the DON revealed that the POA cannot be gotten ahold of. The DON confirmed they had not provided written notification of the room change to Resident 42 or their POA. An interview with SSD on 8/21/2025 at 12:44 PM revealed there was a form that was supposed to be provided to the resident or the resident representative when a room change is considered. This form provided notification and an ability to appeal if necessary.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Licensure Reference Number 175 NAC 12-006.04(A)(iii)(2)Licensure Reference Number 175 NAC 12-006.02(H)Based on record review and interview, the facility failed to complete nurse aide registry checks prior to staff having possible/probable contact with residents for 3 of 6 sampled staff and failed to report an adverse event to the designated agencies as stated in facility policy for 1 resident (Resident 59) of 1 sampled residents. The facility census was 67.Findings Are:A.Review of a facility policy titled Pre-Employment Background Screening and dated 02/01/2024 revealed applicants for employment will receive job offers contingent upon the satisfactory completion of a background screening. A record review of a facility document titled General Orientation Check List dated 08/15/2025 revealed a date of hire for Nurse Aide (NA)-F of 07/30/2025. A record review of a facility document titled Timecard for 07/27/2025 through 08/02/2025 revealed that NA-F worked on 07/30/2025, 07/31/2025 and 08/02/2025. A record review of a facility document titled Public Health Licensure Unit Certification of Licensure and included NA-F full name was dated 08/08/2025. The registry check was completed 10 days after NA-F was hired and began working in the facility. A record review of a facility document titled General Orientation Check List dated 06/12/2025 revealed a date of hire for the Business Office Manager (BOM) of 06/12/2025. A record review of a facility document titled Timecard for 06/08/2025 through 06/14/2025 revealed that the BOM worked on 06/12/2025. A record review of a facility document titled Public Health Licensure Unit Certification of Licensure and included the BOM full name was dated 06/24/2025. The registry check was completed 12 days after BOM was hired and began working in the facility. A record review of a facility document titled General Orientation Check List dated 06/27/2025 revealed a date of hire for Housekeeper (HSK)-J of 06/09/2025. A record review of a facility document titled Timecard for 06/08/2025 through 06/14/2025 revealed that the HSK-J worked on 06/09/2025, 06/10/2025, 06/12/2025, 06/13/2025, and 06/14/2025. A record review of HSK-J's employee records revealed no evidence of the Nurse Aide registry check being completed. In an interview completed on 08/25/2025 at 2:15 PM with the Facility Administrator (FA), the FA confirmed that NA-F and the BOM worked prior to the date listed on the registry check document indicating the registry check was not completed prior to the individuals working in the facility. The FA confirmed that no registry check was completed for HSK-J prior to working in the facility. B.Review of a facility policy titled Vulnerable Adult and dated 10/19/2022 revealed the facility shall report abuse, neglect, and mistreatment of an vulnerable adult as soon as possible after the discovery of the incident. In the section labeled identifying maltreatment, it revealed an adverse event was an untoward, undesirable, and usually unanticipated event that caused death or serious injury, or the risk thereof. A record review of a Resident Dashboard revealed the facility admitted Resident 59 on 08/13/2021 with a diagnosis of spinal stenosis (a condition where the spinal canal or the bony tunnel that protects the spinal cord becomes narrowed causing pain, numbness, and weakness). In an interview completed on 08/20/2025 at 11:18 AM with Resident 59 the resident stated they had suffered from a recent fall. The resident stated that during a transfer from their wheelchair to their bed in the full body lift they fell out of the lift and landed half on their bed and half on the floor. The resident stated that they only suffered some soreness and bruises from the incident. A record review of a facility supplied document titled Witnessed Fall and dated 06/16/2025 revealed that Resident 59 was observed lying on the floor and staff stated the strap on the sling for the full body list broke causing the resident to fall from the lift to the floor. The report listed a predisposing environmental factor of the incident was malfunctioning equipment and the resident was observed to have no injuries from the incident. In an interview completed on 08/21/2025 at 2:30 PM with the facility Director of Nursing (DON), the DON confirmed that this event was an unusual unanticipated event that had the potential to cause serious injury. The DON confirmed that this incident was not reported to the appropriate agencies as outlined in the facility policy.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Licensure Reference Number 175 NAC 12-006.09(D) Based on record review and interview, the facility failed to accurately code the Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) for 2 (Residents 7 and 59) of 17 sampled residents. The facility census was 67. Findings are:A record review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities) dated 10/2023 revealed coding instructions for N0350A to enter the number of days during the 7-day look back period that insulin injections were received. A.A record review of Resident 7's Annual MDS with an Assessment Reference Date of 07/10/2025 revealed Section N0350A to be coded as 1, indicating that the resident had received insulin (an injectable medication) during the assessment look back period. A record review of Resident 7's Medication Administration Record (MAR) for the month of July 2025 revealed that Resident 7 had no documented administrations of insulin. The documentation present reflected that Resident 7 had received Trulicity (an injectable medication used to treat Type 2 Diabetes that is not insulin) 0.75 milligrams on 07/08/2025, which was during the assessment look back period. B.A record review of Resident 59's Quarterly MDS with an Assessment Reference Date of 07/10/2025 revealed Section N0350A to be coded as 1, indicating that the resident had received insulin during the assessment look back period. A record review of Resident 59's MAR for the month of July 2025 revealed that Resident 59 had no documented administrations of insulin. The documentation present reflected that Resident 59 had received Ozempic (an injectable medication used to treat Type 2 Diabetes that is not insulin) 2 milligrams on 07/09/2025, which was during the assessment look back period. In an interview completed on 08/26/2025 at 2:40 PM with the facility Minimum Data Set Coordinator (MDSC), the MDSC stated the facility followed the RAI instructions for the coding of MDSs. The MDSC confirmed that Resident 7 and Resident 59 did not receive insulin during the look back period. The MDSC confirmed that Section N0350A should be coded 0 and not 1 for both residents and this was a coding error.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensure Reference Number 175 NAC 12-006.09(I) Based on observation, interview, and record review the facility failed to prevent accidents and or incidents from occurring for 1 resident (Resident 62) of 1 sampled residents. The facility census was 67. Findings are:A record review of a facility policy titled Vulnerable Adult and dated 10/19/2022 revealed the facility shall take ongoing steps to identify each resident at risk for accidents and adequately plan care and implement procedures to prevent accidents. A record review of Resident 62's Resident Dashboard revealed the facility admitted Resident 62 on 12/03/2024 with diagnoses of schizophrenia (a chronic mental illness characterized by a combination of positive, negative, and cognitive symptoms that significantly impair daily functioning), and bipolar with psychotic features (a severe form of bipolar disorder characterized by the presence of psychotic symptoms, such as delusions and hallucinations, in addition to mood swings). A record review of Resident 62's Quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 06/19/2025 revealed Resident 62 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14/15 indicating the resident was cognitively intact. The resident was documented to have delusions but no other behavioral problems, including wandering. The resident was independent with their activities of daily living and was independently ambulatory throughout the facility without an assistive device. A record review of a facility supplied document titled Risk Assessment: Elopement and dated 06/17/2025 revealed Resident 62 had a score of 4, placing them in the high-risk category for elopement. The assessment stated a total score of 3 or greater is high level of risk and precautions were to be initiated. The assessment stated the resident was independently mobile without an assistive device, had a previous history of wandering, had episodes of disorientation and confusion. In the comments area, documentation was present that the resident was only a moderate risk of elopement and that their wander guard had been removed. A record review of a facility document titled Incidents by Incident Type and dated 08/06/2024 through 08/20/2025 revealed Resident 62 had 1 incident during this period of time described as a witnessed fall. No other incidents or accidents were listed for Resident 62. A record review of Resident 62's physician orders on 08/26/2025 revealed the resident had an order for a wander guard to be in place and functioning on their left ankle. Staff were directed to check for placement and function of the wander guard every shift with a start date of 08/21/2025. A record review of Resident 62's Progress Notes revealed documentation on 08/18/2025 at 9:17 PM that the resident was having aggressive behaviors towards staff and was brought back inside the facility. Additional documentation on 08/19/2025 at 5:53 AM revealed the resident was having aggressive behaviors towards staff and was brought back inside the facility from the courtyard. A record review of a facility supplied document titled Rehab Communication and dated 08/20/2028 revealed documentation that Resident 62 was found outside of the facility and the therapy staff had assisted the resident back into the facility and reported the incident to the charge nurse. There was no other documentation in Resident 62's medical health record about this event. A record review of Resident 62's Progress Notes on 08/21/2024 revealed documentation that on 08/21/2025 a wander guard had been placed to the resident's left ankle due to the resident's exit seeking. In an observation completed on 08/25/2025 at 11:29 AM, a resident in a wheelchair entered the code to the secured front door of the facility, releasing the security device and wheeled themself out the front double doors. Resident 62 walked behind this resident and exited the building onto the unsecured front patio of the building. The resident in the wheelchair that entered the code to the door un-securing it, did not know Resident 62 had exited the building behind them. Resident 62 was outside the building on the patio and had started walking to the sidewalk that leads to a busy street. Licensed Practical Nurse (LPN)-B exited the building approximately 1 minute later, saw Resident 62 and assisted the resident back into the building. In an interview completed on 08/25/2025 at 4:45 PM with the facility Director of Nursing (DON), the DON confirmed that no new or changes to interventions to prevent Resident 62 from exiting the building without staff knowledge had been placed. The DON confirmed that the resident had exited the building without staff knowledge on 08/18/2025 and 08/19/2025 and no incident reports had been completed for these incidents and no changes to interventions to prevent the resident from exiting the building without staff knowledge had been placed on these dates. The DON confirmed a wander guard had been placed on Resident 62 on 08/21/2025 due to the resident's increased exit seeking, and confirmed that no incident reports or interventions were placed from 08/18/2025 through 08/21/2025 to prevent the resident from exiting the

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. Based on record review and interview the facility failed to ensure that residents were provided their required 30-day physician visit for 2 (Residents 47 and 63) of 4 sampled residents. This prevented the residents from receiving a thorough physician assessment of the resident for developing the resident's comprehensive care plan (a written interdisciplinary comprehensive plan to meet the resident's needs), including verifying initial orders and prescribing medication and treatments for the residents. The facility census was 67. Findings are:Record review of the facility policy titled Physician Visits and Physician Delegation dated 3/2025 revealed that it is the policy of the facility to ensure that the physician takes an active role in supervising the care of residents. The physician should see the resident within 30 days of initial admission to the facility. The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by the physician or physician delegate. A. Record review of the admission Record dated 8/26/25 for Resident 47 revealed that Resident 47 admitted into the facility on 6/20/25. Resident 47 had diagnoses of Alzheimer's dementia, anxiety, dyskinesia of the esophagus (a condition where the esophagus, the tube that carries food from the throat to the stomach, experiences abnormal or uncoordinated muscle contractions that can lead to difficulty swallowing, chest pain, and other related symptoms), and high blood pressure. Record review of the Progress Note dated 7/8/25 at 1:27 PM for Resident 47 revealed that the interdisciplinary team discussed Resident 47's 5% weight loss since admission to the facility. Record review of the Medical Record for Resident 47 revealed an admission weight of 126 pounds. Resident 47 weighed 117 pounds on 7/14/25 which was a 7.14% weight loss. Record review of the Progress Note dated 8/19/25 at 8:59 AM for Resident 47 revealed that Resident 47 left the facility with the transportation coordinator for their follow up appointment with the resident's physician. (This was 60 days after the admission date of 6/20/25). Record review of the Physician's Visit Record dated 8/19/25 for Resident 47 revealed that Resident 47 had a 10:00 AM appointment with the resident's physician on 8/19/25. The physician provided a new order for Ensure (a nutritional drink designed to provide essential nutrients and calories to individuals who may not be able to consume adequate nutrition through their diet) or Boost (a drink used to supplement a person's diet with extra nutrients, especially protein and calories, when they are unable to get enough from their regular meals) chocolate with meals and as needed for hunger. The physician signed the order and dated the order 8/19/25. Record review of the Medical Record of Resident 47 revealed no documentation of a required 30 day physician visit for Resident 47. Interview on 8/26/25 at 5:28 PM with the facility Director of Nursing (DON) confirmed that facility residents were required to have a physician visit within 30 days after admission to the facility. The DON confirmed that the facility did not have documentation of an initial 30 day physician visit for Resident 47. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 8/26/25 at 5:37 PM with the Regional Nurse Consultant (RNC) confirmed that the facility had no documentation of an initial 30 day physician visit for Resident 47. The RNC confirmed that a 30 day physician visit was not completed for Resident 47 as required. B. Record review of Resident 63's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 7/10/2025 revealed an admission date of 3/10/2025. Record review of Resident 63's Physician Visit record dated 4/11/2025 revealed an admission date to the facility on 3/10/2025. The physician visit reviewed a history, a current physical and an overview of medications, treatments and reasoning for the visit, which revealed a new admission to a facility and a 30-day review from admission. The physician visit also requested on the provider communication record stating: return visit in 30 days. Record review of Resident 63's Physician Visit record dated 6/10/2025 revealed the order summary report that was printed from the facility on 6/09/2025 and sent with the resident for review with the physician. The order summary report was signed on 6/10/2025 at the end of the report. The physician visit also requested on the provider communication record stating: check labs at next visit, continue current medications and follow up in 60-days. Record review of Resident 63's Physician Visit record dated 8/12/2025 revealed the physician reviewed a history, a current physical and an overview of medications, treatments and reasoning for the visit, which was a 60-day visit. The physician visit requested, under instructions, to return in about 2 months. An interview on 8/26/2025 at 5:15 PM with the Director of Nursing (DON) confirmed that facility residents are required to have a physician visit after admission to the facility every 30 days for the first 90 days, then every 60 days thereafter. Interview on 8/26/25 at 5:45 PM with the Regional Nurse Consultant (RNC) confirmed that the facility had no documentation of a 30-day physician visit for Resident 63 after the initial visit on 4/11/2025 was completed. The RNC confirmed that a 30-day physician visit was completed, however the following physician visit 30 days later was not completed for Resident 63 as required.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, record review, and interview the facility failed to ensure a medication error rate of 5% or less with an actual observed medication error rate of 12%. This affected 1 (Resident 4) of 5 sampled residents. The facility census was 67. Findings are: Record review of a document titled Diclofenac Sodium (a topically applied non-steroidal anti-inflammatory medication) Gel Dosage dated 08/22/2025 revealed the proper amount of gel should be measured using the dosing card supplied. The dosing card should be used for each application of the product. Record review of a document titled Instructions for use Trelegy Ellipta (an inhaled medication) and dated 12/2022 revealed to rinse your mouth with water after you have used the inhaler and spit the water out. Do not swallow the water. Record review of a facility document titled Competency for Inhaler Administration dated 05/11/2021 revealed to instruct the resident to rinse their mouth with water after inhalation of the medication. A record review of Resident 4's Medication Administration Record for the Month of August 2025 revealed that Resident 4 had orders for Trelegy AER 200 micrograms with directions to inhale 1 puff into the lungs once daily and Diclofenac Sodium External Gel 1% with directions to apply 1 gram to both ankles topically twice daily for pain. In an observation of medication administration completed on 08/25/2025 at 10:54 AM by Medication Aide (MA)-G administering medication to Resident 4 the following was observed:-MA-G handed the resident a gray plastic oblong device and informed the resident that it was their inhaler. The resident took 2 deep breaths then on the exhale placed the mouthpiece to their mouth and inhaled. The resident then removed the device from their mouth and gave it back to the MA. The medication aide then applied gloves to both of their hands. The MA used a finger to scoop out an opaque white gel from a clear medication cup. The MA then applied the gel to the residents right ankle. The MA then repeated this process and applied the gel to the right ankle. The medication aide removed their gloves, completed hand hygiene. The MA did not instruct the resident to rinse their mouth after using the inhaler and did not use the measuring device for administration of the topical gel to the resident's ankles to ensure they received the proper dose of the medication. The resident requested an as needed pain medication from the MA voicing a headache rated a 4 on a 1-10 scale. The MA returned to the medication cart, signed out the administered medications and then obtained Acetaminophen (a pain-relieving medication) 1500 milligram tablet and placed it into a clear plastic medication cup. The MA then took the cup to the resident's room and handed the medication to the resident. The resident ingested the medication. The MA then returned to the medication cart. The MA did not obtain the nurses' permission prior to the administration of the as needed medication. In an interview completed on 08/25/2025 at 10:52 AM with MA-G the MA confirmed that they did not have the resident rinse their mouth after use of the inhaler and did not use the dosing card/measuring device to measure out the correct dose of the topically applied medication. The MA also confirmed they did not notify or request the nurse's permission prior to the administration of the as needed medication and should have. In an interview completed on 08/25/2025 at 11:05 AM with Licensed Practical Nurse (LPN)-A, LPN-A confirmed the MA should have informed or gained permission from them as the nurse for the administration of the as needed medication to Resident 4. The LPN confirmed that the MA informed them of the resident's pain level and the administration of the as needed pain medication after they had administered the medication and not before.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Licensure Reference Number 175 NAC 12-006.04(A)(ii)Licensure Reference Number 175 NAC 12-006.18 Based on observation, interview, and record review the facility failed to ensure employee health screens were reviewed prior to the start of employment for 4 of 5 sampled employees and failed to complete hand hygiene per professional standards. These had the potential to affect all residents residing within the facility. The facility census was 67. Findings are:A.A record review of a facility supplied document titled Employee Health History Screen and dated 06/12/2025 was signed as completed by the Business Office Manager (BOM) on 06/12/2025. There was no signature indicating a facility staff member or nurse had reviewed the document prior to the Business Office Manager working in the facility. A record review of a facility supplied document titled Employee Health History Screen and dated 07/30/2025 was signed as completed by Nurses Aide (NA)-F on 07/30/2025. There was no signature indicating a facility staff member or nurse had reviewed the document prior to the Business Office Manager working in the facility. A record review of a facility supplied document titled Employee Health History Screen and dated 07/18/2025 was signed as completed by Nurses Aide (NA)-K on 07/18/2025. There was no signature indicating a facility staff member or nurse had reviewed the document prior to the Business Office Manager working in the facility. A record review of a facility supplied document titled Employee Health History Screen and dated 06/09/2025 was signed as completed by Housekeeper (HSK)-J on 06/09/2025. There was no signature indicating a facility staff member or nurse had reviewed the document prior to the Business Office Manager working in the facility. In an interview completed on 08/25/2025 at 1:35 PM with the facility MDS Coordinator (MDSC) who acts as the facility infection preventionist, the MDSC stated they did not review employee health screens for new employees prior to their start of employment. In an interview completed on 08/25/2025 at 2:50 PM with the Facility Director of Nursing (DON), the DON stated either themselves or the infection preventionist nurse was to review the employee health screens prior to the employee starting employment at the facility. The DON confirmed that the BOM, NA-F, NA-K or HSK-J health history screens were not reviewed and signed by themselves or the infection preventionist nurse prior to those individuals' start of employment at the facility. B. A record review of a facility policy titled Hand Hygiene and dated 11/13/2024 revealed hand washing should be performed by all employees to prevent cross contamination. Hand Hygiene (HH) using soap and water should include rubbing hands together vigorously for at least 20 seconds and the water should be turned off by using a clean paper towel to prevent recontamination. In an observation completed on 08/25/2025 at 10:50 AM of medication administration by Medication Aide (MA)-G it was observed that after applying a topical medication to a resident's ankles with gloved hands, MA-G removed their gloves. The MA then performed hand hygiene with soap and water rubbing their hands together for 11 seconds. The MA then obtained paper towels and dried both of their hands with the paper towels. The MA then used the used paper towels to turn off the water. In an interview completed on 08/25/2025 at 11:05 AM with MA-G, MA-G confirmed that hands are to be washed for a minimum of 20 seconds and that a clean paper towel should be used to turn off the water. In an observation completed on 08/25/2025 at 11:29 AM Licensed Practical Nurse (LPN)-L, LPN-L prepared to obtain a resident's blood glucose reading by a finger stick. The LPN placed the needed supplies on a clean paper towel on the resident's over bed table. The LPN then went to the sink and completed hand hygiene with soap and water rubbing their hands together for 6 seconds. The LPN obtained paper towels and dried off their hands, then used the used paper towels to turn off the water. In an interview completed on 08/25/2025 at 11:35 AM with LPN-L, LPN-L confirmed that they did not rub their hands for at least 20 seconds and did not use a clean paper towel to shut off the sink. In an observation completed on 08/25/2025 at 4:12 PM LPN-B administered eye drops to a resident using gloved hands. The LPN then removed their gloves and completed hand hygiene with soap and water, rubbing their hands together for 5 seconds. The LPN obtained paper towels and dried off their hands, threw the used paper towels away, and used a clean paper towel to shut off the sink. In an interview completed on 08/25/2025 at 4:15 PM with LPN-B, LPN-B confirmed that they did not rub hands for at least 20 seconds during HH and should have. In an interview completed on 08/25/2025 at 4:30 PM with the MDS Coordinator (MDSC) who also acts as the Facility Infection Preventionist, the MDSC confirmed that when using soap and water hands should be rubbed for at least 20 seconds and that a clean paper towel should be used to shut off the water. The MDSC confirmed that hand hygiene under 20 seconds and using the same paper towels to dry hands and shut off the water was not the proper procedure for hand hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285166	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Kenesaw	100 West Elm Avenue Kenesaw, NE 68956

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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. License Reference Number 175 NAC 1-005.06(C) Based on record review and interview, the facility failed to follow Antibiotic Stewardship standards for antibiotic surveillance and monitoring for 1 (Resident 10) of 2 sampled residents. The facility census was 67. Findings are:A record review of a facility policy titled antibiotic Stewardship Program and dated 11/13/2024 revealed the antibiotic stewardship program will optimize the treatment of infections by ensuring the residents who require an antibiotic are prescribed the appropriate antibiotic, reducing the risk for adverse side effects, including the development of antibiotic-resistant organisms from unnecessary or inappropriate antibiotic use to improve resident out comes. The nurse will utilize the appropriate infection criteria protocol based upon signs and symptoms to determine if it is necessary to treat antibiotics or if adjustments in therapy needed to be made. In the event the prescribing practitioner orders an antibiotic without identification of infection criteria, the provider will be requested to identify the rationale for the ordered antibiotic and document in the medical record. The nurse will observe and document in the nurse's notes the effectiveness of the antibiotic, side effects, and potential adverse consequences. A record review of Resident 10's Resident Dashboard revealed that the facility admitted Resident 10 with a diagnosis of dementia (a usually progressive condition marked by the development of multiple cognitive deficits (such as memory impairment, aphasia, and the inability to plan and initiate complex behavior). A record review of Resident 10's comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 06/20/2025 revealed that the resident was at risk for alterations in skin integrity and had none present at the time of the assessments. A record review of Resident 10's Progress Notes revealed that on 07/15/2025 the resident was seen in the facility by the provider. The provider prescribed an oral antibiotic for a diagnosis of cellulitis of the second toe on the left foot. A progress note was also entered that the antibiotic that was prescribed was outside of the recommended dose and frequency. A record review of Resident 10's assessments revealed no assessment indicating the infection criteria protocol was completed or reviewed by the provider prior to prescribing the antibiotic or after prescribing the antibiotic. In an interview conducted on 08/26/2025 at 4:12 PM with the facility MDS Coordinator (MDSC) who also is the facility Infection Preventionist, the MDSC stated that an antibiotic time out was to be completed 24-48 hours after the start of an antibiotic. This check was to review the appropriateness of the antibiotic and to update the provider that prescribed it, if necessary, about the use and appropriateness of the antibiotic prescribed. The MDSC confirmed that this process was not followed for Resident 10's antibiotic. The MDSC also confirmed that an assessment indicating the appropriate infection criteria was met or not met was not completed and communicated to the prescribing provider indicating the provider was made aware of the infection meeting or not meeting criteria. The MDSC also confirmed that the provider was not notified about the antibiotic that was being prescribed was outside of the recommended dose and frequency for the medication being prescribed. The MDSC confirmed that antibiotic stewardship standards were not being followed.