STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285180	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Butte Senior Living	210 Broadway Butte, NE 68722

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51391 Licensure Reference Number 175 NAC 12-006.02(H) Based on record review and interview; the facility failed to report an incident to the State Agency related to an incident between Resident 3 and 23. The sample size was 2 and the facility census was 26. Findings are: A. Review of Abuse Policy: Review of the facility policy Vulnerable Adult last updated 10/19/22 revealed the following: -all residents living in the facility were vulnerable, -abuse was the willful (the individual acted deliberately) infliction of injury with resulting physical harm, pain, or mental anguish, -instances of abuse included verbal, sexual, physical, and mental, -any act against a vulnerable adult including assault, battery, or sexual conduct, -any sexual contact with a vulnerable adult who is impaired in judgement or capacity by mental or emotional dysfunction or under influence and is therefore unable to consent to the sexual conduct, -a mandated reporter would immediately report to their Supervisor, after making sure the resident was safe and the Supervisor would immediately report to the Director of Nursing (DON) or the Administrator, -the Administrator would determine if the incident/allegation meets the criteria for Reportable Incident, and all incidents deemed reportable would be submitted to Adult Protective Services (APS), -the Supervisor, DON, or Administrator would immediately institute an internal investigation including interviews of staff, residents, witnesses, resident health status, behavior review, and a medication review, and (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the Administrator would submit the report the Department of Health and Human Services (DHHS). B. Review of Resident 3's Minimum Data Set (MDS-federally mandated comprehensive assessment tool used to develop resident care plans) dated 9/18/24 revealed the resident had severe cognitive impairment and had a diagnosis of: Non traumatic Brain Dysfunction, Non-Alzheimer's Dementia and Unspecified Dementia, Unspecified Severity with other behavioral Disturbance. A review of Resident 3's Medical Record revealed on 10/14/2024 at 4:45 PM Resident 3 was seen kissing another resident (Resident 23) on the mouth. Both residents were unaware cognitively of the inappropriateness of the exchange. The residents were sitting in the living room socializing with staff and other residents and were separated as soon as staff observed the residents kissing, staff continued to monitor the residents to prevent further interaction. The Administrator and charge nurse were notified of the event that was observed by Social Services Director - L. Review of the facility form Care Conference Summary from 10/17/24 revealed that Resident 3's behaviors were reviewed with family and that hand holding is OK, but no hanky panky or friskiness. C. On 10/30/24 at 4:20 PM during an interview, the facility Administrator confirmed the incident from 10/14/24 between Resident 3 and 23 was not reported to APS. 45739 D. Review of Resident 23's MDS dated [DATE] revealed the resident had severe cognitive impairment, diagnoses of Alzheimer's Disease and non-Alzheimer's Dementia and required assistance with toileting and dressing. Review of Resident 23's Care Plan, last revised on 10/10/24 revealed the resident: -had severe cognitive decline, was confused to time and place, and had long and short-term memory problems, -required assistance with dressing and toileting, and -had a history of kissing a male resident who resided in the facility, staff were to redirect the resident by explaining the behavior was not acceptable. Review of the facility form Care Conference Summary dated 10/10/24 regarding Resident 23 revealed the behaviors were discussed with Resident 23's family and they were okay with hand holding and a quick peck, but the family did not want any frisky behaviors. Review of Resident 23's Progress Notes revealed an entry on 10/14/24 at 4:08 PM this Resident was seen kissing another resident on the mouth. Both residents were unaware cognitively of the inappropriateness of the exchange. They were separated and were monitored, and the Administrator was notified. Further review revealed no documentation the incident on 10/14/24 was reported to the State Agency. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 10/30/24 at 4:20 PM with the Administrator confirmed the incident on 10/14/24 was not reported to the State Agency.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51391 Licensure Reference Number 175 NAC 12-006.09(F)(iii) Based on record review and interview; the facility failed to review and revise the care plan interventions related to behaviors for Resident 3 and 23. The sample size was 2 and the facility census was 26. Findings are: A. Review of Resident 3's Minimum Data Set (MDS-federally mandated comprehensive assessment tool used to develop resident care plans) dated 9/18/24 revealed the resident had severe cognitive impairment and had a diagnosis of: Non traumatic Brain Dysfunction, Non-Alzheimer's Dementia and Unspecified Dementia, Unspecified Severity with other behavioral Disturbance. A review of Resident 3 Medical Record revealed on 10/14/2024 at 4:45 Resident 3 was seen kissing another resident (Resident 23) on the mouth. Both residents were unaware cognitively of the inappropriateness of the exchange. The residents were sitting in the living room socializing with staff and other residents and were separated as soon as staff observed the residents kissing, staff continued to monitor the residents to prevent further interaction. The Administrator and charge nurse were notified of the event that was observed by Social Services Director - L. Review of the care plan with a revision date of 10/10/24 revealed that the behavior of resident 3 on 10/14/24 was not on the care plan. Review of the Care Conference Summary from 10/17/24 revealed that resident behaviors were reviewed with family and that hand holding is OK, but no hanky panky or friskiness. B. An interview with MDS Coordinator, MDS-N, confirmed the care plan was not updated related to the incident on 10/14/24 behavior interventions. 45739 C. Review of Review of Resident 23's MDS dated [DATE] revealed the resident had severe cognitive impairment, diagnoses of Alzheimer's Disease and non-Alzheimer's Dementia and required assistance with toileting and dressing. Review of Resident 23's Care Plan, last revised on 10/10/24 revealed the resident: -had severe cognitive decline, was confused to time and place, and had long and short-term memory problems, -required assistance with dressing and toileting, and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-had a history of kissing a male resident who resided in the facility, staff were to redirect the resident by explaining the behavior was not acceptable. Further Review of Resident 23's Care Plan revealed no documentation related to an incident that occurred on 10/14/24 involving Resident 3 and 23 kissing with no interventions documented. Review of the facility form Care Conference Summary dated 10/10/24 related to Resident 23 revealed the facility discussed the behavior of kissing with the resident's family and they were okay with hand holding (with Resident 3) because it provided comfort to both residents. Interview on 10/30/24 at 4:20 PM with the Administrator confirmed that the incident from 10/14/24 and behavior interventions were not implemented onto Resident 23's Care Plan.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.09(H)(i)3 Based on observations, record review and interviews; the facility failed to provide assistance with toileting and incontinence cares for 4 (Residents 11, 7, 3 and 6) of 8 sampled residents who required assistance with all activities of daily living. The facility census was 26. Findings are: A. Review of Resident 11's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 9/30/24 indicated the resident was admitted [DATE] with diagnoses of non-traumatic brain disfunction, Alzheimer's disease, End Stage Renal Disease (ESRD) and non-Alzheimer's dementia. The MDS identified the resident's cognition was severely impaired, the resident required substantial to maximal staff assistance with toileting hygiene, dressing, personal hygiene, and transfers, and was frequently incontinent of bowel and always incontinent of bladder. Review of Resident 11's current Care Plan with a revision date of 8/21/24 revealed the resident had a self-care deficit related to a decline in physical functioning. The resident was incontinent of bowel and bladder and utilized an incontinent product for dignity. The care plan identified an intervention to assist the resident with toileting before and after each meal, midafternoon, at bedtime and as needed. Review of a Continence Evaluation dated 9/30/24 at 8:12 PM revealed the resident was frequently incontinent of urine and occasionally involuntary of bowel. The resident required assist with toileting hygiene and due to impaired cognition, the resident had difficulty with understanding what staff were trying to do when toileting the resident. Observations of Resident 11 on 10/29/24 from 7:38 AM to 5:10 PM revealed the following: -7:38 AM the resident was dressed and was seated in a recliner in the commons area. The resident had eyes closed as if asleep. -8:22 AM the resident was transferred by Nurse Aide (NA)-C from the recliner into a wheelchair and was assisted out to the dining room for the breakfast meal. -9:33 AM the resident was assisted from the dining room by NA-G and transferred back to a recliner in the commons area. Resident 11 was not offered an opportunity to use the bathroom and was not checked for potential incontinence. -10:43 AM the resident remained in the commons area and watched television. -11:44 AM the resident was assisted into the dining room for a group activity and then positioned at the table for the noon meal. Resident 11 was not provided assistance with toileting and/or incontinence cares before going out to the dining room. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-2:00 PM the resident was assisted out of the dining room by NA-G and was transferred into a recliner in the commons area. The resident was still not offered an opportunity to use the bathroom and was not checked for potential urinary incontinence. -4:35 PM the resident remained in the recliner. The resident stood independently at this time and started to rub the resident's lower back. The resident was approached by Licensed Practical Nurse (LPN)-H who encouraged the resident to sit down, but the resident refused. The resident indicated needing help and wanted to go to the resident's room. -5:00 PM NA-C assisted the resident into the bathroom and the resident's urinary incontinence brief was found to be heavily soiled with urine. During an interview on 10/29/24 at 5:08 PM, NA-C confirmed Resident 11 was last toileted at around 7:30 AM that morning and was not toileted again or checked for incontinence until 5:00 PM (9 1/2 hours later). NA-C confirmed the resident was to be toileted before and after meals, in the afternoon and when the resident was assisted to bed. NA-C indicated due to staffing levels it was difficult to get all the residents toileted in a timely manner. B. Review of Resident 7's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of non-traumatic brain dysfunction, ESRD, Alzheimer's disease, and non-Alzheimer's dementia. The resident was dependent on staff for toileting hygiene, dressing, personal hygiene, and transfers and was always incontinent of bowel and bladder. Review of the resident's current Care Plan revised on 8/19/24 revealed the resident was non-ambulatory, required use of the mechanical lift (device used to transfer residents) for all transfers and toileting and was frequently incontinent. The care plan identified an intervention to assist the resident with toileting before and after each meal, midafternoon, at bedtime and as needed. Review of the resident's Continence Evaluation dated 8/5/24 at 11:24 AM revealed the resident was incontinent of bowel and bladder, utilized incontinent products for dignity and required assistance with toileting. Observations of Resident 7 on 10/29/24 from 7:15 AM to 10:33 AM revealed the following: -7:15 AM the resident was seated in a wheelchair in the resident's room. -9:22 AM the resident was assisted from the dining room to the resident's room per the wheelchair after the breakfast meal. Resident 7 was placed in front of the television and was not offered an opportunity to use the bathroom and was not checked for potential urinary incontinence. -10:33 AM the resident remained positioned in front of the television. NA-C and NA-G transferred the resident into the bathroom. Resident 7 was incontinent of both bowel and bladder. During an interview on 10/29/24 at 11:05 AM, NA-C confirmed the following regarding Resident 7: -was to be assisted with toileting and/or incontinence management before and after all meals. -was assisted out of bed and was toileted that morning at 6:30 AM. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-was taken to the resident's room after the breakfast meal at 9:22 AM but no toileting cares were offered. -was toileted at 10:33 AM (4 hours later) and was incontinent of bowel and bladder at that time. Surveyor: [NAME], [NAME] K. C. Review of Resident 3's MDS dated [DATE] indicated the resident was admitted [DATE]. The MDS identified the resident's cognition was severely impaired, with a diagnosis of Non-Traumatic Brain Dysfunction, Non-Alzheimer's Dementia, Depression and Unspecified Dementia, and Unspecified Severity with other Behavioral Disturbance. The resident was frequently incontinent of bowel and bladder, required maximal assistance with toileting hygiene, dressing, and was independent with transfers and ambulation. Review of Resident 3's Care Plan with a revision date 10/10/24 revealed the resident was frequently incontinent of bowel and bladder, utilized incontinent products for dignity and required maximum assist with toileting hygiene. The care plan identified an intervention to assist the resident with toileting cares upon rising, before and after meals, midafternoon, at bedtime and as needed. The resident required assistance of two staff for toileting hygiene after each incontinent episode. Observations of Resident 3 on 10/29/24 from 8:10 AM to 2:25 PM revealed the following: - 8:10 AM the resident was sitting in the dining room at table eating breakfast, -10:05 AM the resident was sitting up on edge of bed, stood up independently, ambulated to the doorway, looked out into the hall and then ambulated back to bed and laid down, -11:38 AM The resident was lying in bed with eyes closed, -11:55 AM The Administrator woke resident up for dinner, did not offer to assist resident with toileting cares or check for potential incontinence, Administrator walked with resident to the dining room for dinner, -12:40 PM The resident was in the dining room eating dinner independently, and -2:14 PM NA-G assisted the resident to the bathroom, the resident's pull up was heavily soiled with urine. During an interview on 10/29/24 at 2:25 PM, NA-C confirmed Resident 3 was last toileted around 7:00 AM that morning before breakfast and was not toileted again or checked for incontinence until 2:15 PM (7 hours later). NA-C confirmed the resident was to be assisted with toileting cares, with morning cares, before and after meals, in the afternoon and at bedtime. NA-C indicated that toileting cares are difficult to complete on all the residents with the number of staff that was scheduled. D. Review of Resident 6's MDS dated [DATE] indicated the resident was admitted [DATE]. The MDS identified the resident cognition was severely impaired with a diagnosis of Non-Traumatic Brain Dysfunction and Dementia. The resident was frequently incontinent of urine and occasionally incontinent of bowel, required maximal assistance with toilet hygiene, dressing, bed mobility and transfers, and was dependent on staff for wheelchair mobility. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 6's Care Plan with a revision date of 10/28/24 revealed the resident was frequently incontinent of bladder and occasionally incontinent of bowel, utilized incontinent products for dignity and required maximum assistance for toileting hygiene. The care plan identified an intervention to assist the resident with toileting cares before and after meals, midafternoon, at bedtime, and as needed. Observations of Resident 6 on 10/29/24 from 8:20 AM to 2:00 PM revealed the following: -8:20 AM: the resident was sitting in the dining room at the breakfast table, awake, sipping on water, -10:14 AM: the resident was sitting in recliner with eyes closed cuddling a baby doll, -11:30 AM the resident was sitting in recliner with her eyes closed, -11:55 AM the Administrator pivot transferred the resident into the wheelchair and assisted the resident to the dining room for the dinner meal, -12:30 PM the resident was sitting at the dining room table, eyes closed, a plate of food was on the table untouched, -12:56 PM staff woke the resident up to eat, the resident started eating independently, -1:25 PM the resident was sitting at the dining room table, the resident's plate and glasses were removed from the table, -1:50 PM the resident was assisted out of the dining room to her room, and -1:55 PM NA-G and NA-C assisted resident to the bathroom, resident's pull-up was soiled with urine. During an interview on 10/29/24 at 2:05 PM, NA-C confirmed Resident 6 was last toileted at 9:00 AM that morning after breakfast and was not toileted again or checked for incontinence until 2:00 PM (4 hours later). NA-C confirmed that the resident was to be toileted before and after meals, in the afternoon, at bedtime and as needed. 51391

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.09(I) Based on observation, interview, and record review; the facility failed to determine causal factors for falls, implement fall prevention measures and a review and revise fall prevention measures for Residents 22 and 77. The sample size was 3 and the facility census was 26. Findings are: A. Review of the Risk Management policy with a revision date of 9/27/24 revealed the following: -All accidents/incidents involving residents would be reported, investigated, and reviewed to ensure residents received the highest quality of care. -The nurse identifying an incident was responsible for completing the incident report including an incident description (including the resident's description), immediate action taken and assessment at the time of the incident with interventions initiated. -Additional information as needed. -All Incident Reports and investigations were completed by the end of a work shift and the Director of Nursing (DON), the Executive Director (ED) and the Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) Nurse reviewed risk management notes to identify new incidents, to ensure interventions were appropriate and care planned. B. Review of Resident 22 's Minimum Data Set (MDS) dated [DATE] revealed the following: -The resident's cognitive status was severely impaired with fluctuating disorganized thinking and delusions. -Diagnosis included brain disfunction and Dementia. -The resident received substantial assistance with dressing, transfers, and toileting hygiene. -The resident had occasional bladder incontinence -The resident had 2 or more falls without injury, and 2 or more falls with minor injury. Review of Resident 22's Care Plan with a revision date of 10/26/24 revealed the following: -The resident required assistance with Activities of Daily Living (ADL's), (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-was at risk for falling, had a history of falls and staff were to provide the following interventions; 2 person assist for transfers, a scoop mattress (mattress with elevated/defined edges used to make the occupant aware of the location of the mattress edge), leaving a call light within reach, continue with behavior medications as ordered and monitor the effects, encourage mobility, ensure appropriate footwear such as good shoes, gripper socks, or bedroom slippers with soles, a motion sensor in the resident's room, leaving the resident's door open, and a fall mat beside the resident's bed. -The resident was hospitalized on [DATE] for evaluation due to hallucinations (seeing things not present), delusions (fixed firm belief with no evidence of reality), several falls and an inability of the facility to keep the resident safe. -Review of Resident 22's Fall Reviews from 6/11/24 through 10/28/24 revealed the following: -6/11/24 at 1:45 PM the resident was found sitting on the floor of the resident room and reported falling on the way to the bathroom. The intervention was to replace the antiskid strips in the front of the resident's chair, as the resident reported the floor was so slick. -6/17/24 at 8:20 PM the resident was seen sitting in the doorway of the resident room with pants down around knees, and the resident thought there was smoke in the room. The intervention was to leave the door to the room open for closer monitoring by staff. -6/21/24 at 6:00 AM the resident was found on floor after rolling out of bed and hitting head. The determined cause was falling out of bed. A fall mat was placed beside the bed to protect the resident. -7/5/24 at 8:45 AM the resident was sitting on the floor in front of the recliner and reported I was getting up and fell and thought there was smoke in the room. The intervention was to have the Doctor conduct a medication review. There was no evidence of medication review until 7/11/24 (6 days after the fall) and no evidence a change was made based on the review. -7/15/24 at 7:00 PM the resident was found on the floor. The resident reported walking back from the bathroom and going down to the knees. The resident was independently ambulating without appropriate footwear and appropriate footwear was put on. It was unclear why the resident did not have on appropriate footwear as this was previously implemented. -7/24/24 at 6:15 PM the resident's foot got caught in an overbed table while lifting a recliner footrest. A small abrasion occurred. The bedside table was relocated. There was no evidence where the bedside table was to be located moving forward. -7/27/24 at 6:10 AM the resident was found sitting on the floor. It was determined the resident's motion sensor alarm had been deactivated so the alarm was reactivated. The resident was reminded to use the call light. There was no documentation or investigation to determine why the alarm was not initially activated. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/29/24 at 6:40 PM the resident was sitting on the floor of the room covered in Bowel Movement (BM) and the resident's ostomy (external exit or artificial opening in which the colon is diverted to the abdominal wall) bag had become loose. The resident did not have their call light and the motion sensor was activated. The intervention was for staff to toilet the resident upon rising, before and after meals and as needed. -8/7/24 at 5:40 PM a Nurse Aide (NA) assisted resident from their recliner to a standing position. The walker wheels were not moving freely, and the resident fell backward onto her buttocks on the floor. The walker was evaluated, and tennis balls were placed on the back legs. -8/9/24 at 5:50 AM staff were assisting the resident to walk from the bathroom and the resident turned too early and missed the chair. Staff lowered resident to the floor. The cause was listed as shoes were not fitting properly. The intervention was to use slipper socks. There was no evidence this was a new intervention as staff were already to be utilizing appropriate footwear. -8/9/24 at 6:40 AM the resident was heard calling for help, found lying face down in the room with blood pooling on the floor from a cut inside the resident's mouth. The resident was reportedly delusional and hallucinating. The Doctor was notified and reviewed resident's condition. As a result, the Resident started on Seroquel (an antipsychotic (class of drugs used to treat symptoms of psychosis)) daily at bedtime. -8/17/24 at 2 PM the resident was having increased delusion, hallucinations, and behaviors. A medication audit was completed by the Director of Nursing (DON) and it was determined the resident did not receive the ordered antipsychotic medication Seroquel on 8/9, 8/10, 8/11, 8/14, 8/15, and 8/16. The nurse responsible received disciplinary action. -8/26/24 at 11:00 PM while the resident was being assisted to the bathroom the resident did not turn well enough toward the toilet and sat down on the floor. The intervention was to use a 2 person assist. There was no evidence this was a new intervention, as it had been implemented for a previous fall. -9/28/24 at 6:35 AM The resident was found on the floor beside the bed and reported hearing someone calling the resident's name. The facility determined the resident was delusional. The facility was awaiting an appointment with a psychiatric provider and a scoop mattress was placed on the bed. -9/28/24 at 8:58 PM the resident was found on the floor in front of the recliner, reported putting self-there, and reported that people on the television were calling the residents' name. The television was turned down and resident was assured of safety. -9/28/24 at 9:55 PM the resident was found sitting on the floor of the resident's room scooting self. The resident reportedly slid out of the recliner and reported hiding from people calling out the resident's name on the television. Again, the television volume was turned down and resident was reminded of safety. There was no evidence of new interventions being implemented. -9/29/24 at 5:18 AM the resident was found on the knees beside the recliner. Staff reported a lack of sleep. The facility was awaiting medication review by a psychiatric provided scheduled for 10/7/24. There was no evidence of new interventions being implemented. (continued on next page)

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	285180	A. Building B. Wing	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Butte Senior Living	210 Broadway Butte, NE 68722

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-9/30/24 at 4:40 PM the resident was found sitting on the floor of the resident room. The resident reported trying to get to the chair. It was determined the residents motion detector was on and working. There was no evidence of new interventions being implemented. -9/30/24 at 7:00 PM the resident was found sitting on the floor beside the recliner. The resident was delusional about a granddaughter needing an ambulance. The facility provided 1:1 (one on one) supervision until the resident settled down and again reported they would await the scheduled mental health provider appointment. There was no evidence of new interventions being implemented. -10/2/24 at 1:15 AM the resident was found sitting on the floor and reported getting up to go to the bathroom but ended up sitting on the floor and scooting to the doorway to get staff's attention. The staff provided assistance to the toilet and provided 1:1 until the resident was settled. There was no evidence of new interventions being implemented. -10/11/24 at 1:12 AM the resident was found sitting on the floor between the bed and small table beside the recliner. The resident continued to have delusions. The facility implemented hourly checks. -10/14/24 at 11:30 PM the resident was reportedly on the floor looking for the baby. The facility reported they were awaiting therapeutic effects from medication changes. There was no evidence of new interventions being implemented. -10/16/24 at 7:00 AM the resident was found sitting on the floor and reported I didn't fall I scooted out of the chair and over here. The facility indicated they continued to monitor the resident's response to a medication change. There was no evidence of new interventions being implemented. -10/25/24 at 12:06 PM the resident was found sitting on the floor and again reported putting self there. The resident continued to have delusions and hallucinations. The residents' medications had been adjusted and facility was still monitoring for therapeutic effects. There was no evidence of new interventions being implemented. -10/26/24 at 10:05 AM the resident was found lying on the floor and reported left knee pain. The resident continued to have delusions and was assisted to bed for safety. There was no evidence of new interventions being implemented. -10/26/24 at 5:50 PM the resident was found sitting on the floor and reported putting self on the floor due to looking for papers. The resident continued to have delusions and the resident's medication had been recently updated and facility continued to wait on and monitor the therapeutic medication effects. It was also noted that a Mental Health Practitioner had started therapy. There was no evidence of new interventions being implemented. -10/26/24 at 6:40 PM the resident was on the floor again and reported getting on the floor on purpose. The facility implemented 30-minute checks. -10/26/24 at 7:10 PM the resident found on the floor (when staff returned to check after 30 minutes) the resident's room door was left open to allow for additional observation and the resident was left alone to calm self as staff presence was escalating behaviors. Leaving the resident's room door open was not a new intervention. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-10/26/24 at 7:25 PM the resident report indicated the resident fell two more times while the nurse was attempting to call the on-call provider to get orders to send the resident to the hospital for evaluation. The resident transferred to the hospital for safety. During an interview on 10/30/24 at 2:48 PM the Director of Nursing (DON) confirmed the facility did not always implement new interventions and determine causal factors to prevent ongoing falls for resident 22. In addition, the DON confirmed waiting a week or more to expect therapeutic effects from medication changes following falls, waiting up to 6 days for a medication review, and/or not implementing new, or coming up with additional interventions was not preventing ongoing falls for Resident 22. In addition, the facility did not have staff adequate to provide ongoing 1:1 services for Resident 22, which was indicated to prevent ongoing falls given the resident's delusions/hallucinations and ongoing falls. During an observation of Resident 22 on 10/31/24 at 7:15 AM the resident was seen lying in the bed. The resident's bed was in a low position and a call light was in reach, however there was not a fall mat beside the bed. During an observation of the provision of care for Resident 22 on 10/30/24 Nurse Aid (NA)-L and Licensed Practical Nurse (LPN)-P entered the resident's room pushing the resident in a wheelchair after leaving the dining room and transferred the resident using a gait belt into the recliner in the resident's room. The staff did not offer or encourage toileting. During further interview on 10/31/24 at 10:00 AM the DON confirmed that Resident 22 was supposed to have a fall mat beside the bed when it was occupied and confirmed that at 7:15 AM on 10/31/24 the fall mat was not in use. In addition, the DON confirmed that staff were to assist the resident to the toilet before and after meals which was not completed after the breakfast meal on 10/31/24. 29638 C. Review of Resident 77's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of traumatic brain disfunction, arthritis and coronary artery disease. The following was assessed for the resident: -cognition was severely impaired. -behavior of wandering which placed the resident at significant risk of getting into potentially dangerous places. -history of falls, with one fall without injury since admission. Review of Resident 77's Fall Review dated 10/6/24 at 9:15 PM revealed the resident was on the floor. The resident had been very agitated and anxious and had required 1:1 from the staff. The provider was notified, and a new order was received for Risperdal (medication used to treat schizophrenia, and bipolar disorder by regulating mood, behaviors, and thoughts) 0.5 milligrams (mg) as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Fall Review dated 10/26/24 at 7:00 PM revealed the resident was found on the floor by a dietary staff. The resident had been restless throughout the day with no effective interventions. No causal factors were identified, current interventions were not revised, and no new fall interventions were developed. Review of a Fall Review dated 10/30/24 at 7:50 AM revealed the staff heard the resident calling out and found the resident on the floor next to the bed. The resident had on regular socks at the time of the fall. The staff determined the resident slipped off the edge of the bed due to socks. A new intervention was put into place for the resident to wear gripper socks when not wearing shoes. Review of a Fall Review dated 10/30/24 at 11:06 PM revealed the resident was observed attempting to get up and out of the resident's bed by crawling and sliding to the ground. Further review of the assessment revealed the resident was not wearing gripper socks at the time of the fall. A new intervention was put into place to place the resident's bed in the lowered position when the resident was in bed. During an interview with the DON on 10/31/24 at 8:32 AM, the following was confirmed: -10/6/24 at 9:15 PM the resident was found on the floor. The resident had been agitated and required 1:1 staff monitoring. A new order was initiated for Risperdal. -10/26/24 at 7:00 PM the resident was found on the floor. No causal factor was identified, and no new interventions were developed. -10/30/24 at 7:50 AM the resident was up walking in the resident's room and fell . The resident was wearing regular socks at the time and a new intervention was developed for the resident to wear gripper socks when not wearing shoes. -10/30/24 at 11:42 PM the resident attempted to get out of bed and fell . Staff failed to implement the new intervention for the gripper socks. A new intervention was identified to place the resident's bed in the lowest position.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.04(D) Based on observations, record reviews and interviews; the facility failed to ensure sufficient staffing to meet the safety needs of Residents 22 and 77, and to provide timely toileting assistance for Residents 3, 6, 7 and 11. The total sample size was 22 and the facility census was 26. Findings are: A. Review of Resident 11's Minimum Data Set (MDS- a federally mandated comprehensive assessment tool used for care planning) dated 9/30/24 indicated the resident was admitted [DATE] with diagnoses of non-traumatic brain disfunction, Alzheimer's disease, End Stage Renal Disease (ESRD) and non-Alzheimer's dementia. The MDS identified the resident's cognition was severely impaired, the resident required substantial to maximal staff assistance with toileting hygiene, dressing, personal hygiene, and transfers, and was frequently incontinent of bowel and always incontinent of bladder. Observations of Resident 11 on 10/29/24 from 7:38 AM to 5:10 PM revealed the following: -7:38 AM the resident was dressed and was seated in a recliner in the commons area. The resident had eyes closed as if asleep. -8:22 AM the resident was transferred by Nurse Aide (NA)-C from the recliner into a wheelchair and was assisted out to the dining room for the breakfast meal. -9:33 AM the resident was assisted from the dining room by NA-G and transferred back to a recliner in the commons area. Resident 11 was not offered an opportunity to use the bathroom and was not checked for potential incontinence. -10:43 AM the resident remained in the commons area and watched television. -11:44 AM the resident was assisted into the dining room for a group activity and then positioned at the table for the noon meal. Resident 11 was not provided assistance with toileting and/or incontinence cares before going out to the dining room. -2:00 PM the resident was assisted out of the dining room by NA-G and was transferred into a recliner in the commons area. The resident was still not offered an opportunity to use the bathroom and was not checked for potential urinary incontinence. -4:35 PM the resident remained in the recliner. The resident stood independently at this time and started to rub the resident's lower back. The resident was approached by Licensed Practical Nurse (LPN)-H who encouraged the resident to sit down, but the resident refused. The resident indicated needing help and wanted to go to the resident's room. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-5:00 PM NA-C assisted the resident into the bathroom and the resident's urinary incontinence brief was found to be heavily soiled with urine. During an interview on 10/29/24 at 5:08 PM, NA-C confirmed Resident 11 was last toileted at around 7:30 AM that morning and was not toileted again or checked for incontinence until 5:00 PM (9 1/2 hours later). NA-C confirmed the resident was to be toileted before and after meals, in the afternoon and when the resident was assisted to bed. NA-C indicated due to staffing levels it was difficult to get all the residents toileted in a timely manner. B. Review of Resident 7's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of non-traumatic brain disfunction, ESRD, Alzheimer's disease, and non-Alzheimer's dementia. The resident was dependent on staff for toileting hygiene, dressing, personal hygiene, and transfers and was always incontinent of bowel and bladder. Observations of Resident 7 on 10/29/24 from 7:15 AM to 10:33 AM revealed the following: -7:15 AM the resident was seated in a wheelchair in the resident's room. -9:22 AM the resident was assisted from the dining room to the resident's room per the wheelchair after the breakfast meal. Resident 7 was placed in front of the television and was not offered an opportunity to use the bathroom and was not checked for potential urinary incontinence. -10:33 AM the resident remained positioned in front of the television. NA-C and NA-G transferred the resident into the bathroom. Resident 7 was incontinent of both bowel and bladder. During an interview on 10/29/24 at 11:05 AM, NA-C confirmed the following regarding Resident 7: -was to be assisted with toileting and/or incontinence management before and after all meals. -was assisted out of bed and was toileted that morning at 6:30 AM. -was taken to the resident's room after the breakfast meal at 9:22 AM but no toileting cares were offered. -was toileted at 10:33 AM (4 hours later) and was incontinent of bowel and bladder at that time. -NA-C felt more staff was needed to make sure the resident's needs were met. C. Review of Resident 77's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of traumatic brain disfunction, arthritis and coronary artery disease. The following was assessed for the resident: -cognition was severely impaired. -behavior of wandering which placed the resident at significant risk of getting into potentially dangerous places. -history of falls, with one fall without injury since admission. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 77's Nursing Progress Notes revealed the following: -10/3/24 at 11:39 PM the resident was restless and agitated after the evening meal. The resident did not accept redirection and attempted to exit out 3 of the facility doors. -10/6/24 at 9:15 PM the resident was observed on the floor. Prior to this fall, the resident had required 1:1 from the staff due to anxiety level. -10/7/24 at 2:55 PM the resident had been attempting to exit the facility and required multiple attempts to redirect before calming down. -10/12/24 at 5:49 PM the resident refused assistance with cares and set off the door alarms multiple times and was difficult to re-direct. -10/15/24 at 2:29 PM the resident had wandering behaviors, and very little redirection was effective. -10/16/24 at 4:07 PM the resident required 1:1 from the staff due to anxiety/agitation and exit seeking. -10/16/24 at 6:14 PM the resident was very confused and was unable to be redirected. The resident set off the door alarms multiple times. Exit seeking continued for 3 hours and the resident required 1:1 redirection from several different staff. Behaviors continued to escalate throughout the afternoon. -10/17/24 at 3:17 PM the resident was exhibiting increased anxiety with wandering behaviors. The resident received 1:1 redirection but the staff were unsuccessful with alleviating behaviors. -10/17/24 at 5:59 PM the resident required 2 staff members to be with the resident most of the shift. The resident was exit seeking, aggressive and argumentative. The resident took staff away from other residents in order to meet needs. -10/19/24 at 10:27 AM the resident required 1-2 staff members for most of the morning due to exit-seeking and aggressive behaviors. Staff were unable to redirect for a significant amount of time. The resident's behaviors and aggression have impacted the timeliness that staff have been able to respond to the needs of other residents. -10/19/24 at 11:34 AM the resident required 1-2 staff members for much of the morning due to exit seeking and aggressive behaviors. No effective redirection. -10/19/24 at 12:55 PM the resident was a near constant 1:1 taking away needed staff to assist other residents. -10/20/24 at 5:48 PM the resident continued to require 1-2 staff members for most of the afternoon due to exit seeking and aggression. The resident was a 1:1 and at times a 2:1 causing staff to be unable to assist other residents. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/22/24 at 3:52 PM the resident required 1:1 staff redirection for most of the afternoon. At times 2 staff were needed to assure the resident's safety and the resident's behaviors impacted the timeliness that staff have been able to respond to the needs of other residents. -10/23/24 at 5:57 PM the resident had behaviors of exit seeking and agitation and required 1:1 with the Administrator for an extended period of time. -10/25/24 at 10: 26 AM the resident was agitated, verbally abusive to staff and attempted to fall on the staff. The resident was a 2:1 or a 1:1 with staff members. -10/25/24 at 11:15 PM the resident had increased restlessness and agitation with verbal and physical behaviors toward the staff. The resident's constant needs for 1:1 or 2:1 to ensure the resident's safety has taken away time that is needed to care for other residents. -10/26/24 at 7:00 PM revealed the resident was found on the floor by a dietary staff. The resident had been restless throughout the day with no effective interventions. -10/27/24 at 5:35 PM the resident was confused and delusional and was attempting to ambulate independently and without the walker. The resident was exit seeking and had set off the door alarms multiple times. -10/30/24 at 7:50 AM the staff heard the resident calling out and found the resident on the floor next to the bed. -10/30/24 at 11:06 PM the resident was observed attempting to get up and out of the resident's bed by crawling and sliding to the ground. During an interview on 10/29/24 at 2:13 PM, Licensed Practical Nurse (LPN)-H confirmed due to the resident's ongoing behaviors, the staff have had to provide with 1:1 and even 2:1 at times to keep the resident and other residents safe. The resident has been physically and verbally aggressive towards the staff and with unsteadiness and behaviors was at an increased risk for falls. LPN-H verified the facility needed additional staff to meet this resident's behavior and safety needs and to make sure the other residents received the assist they needed. D. During an interview with the Director of Nursing (DON) on 10/30/24 at 7:35 AM the DON confirmed with the facility's current staffing levels it was difficult to maintain toileting schedules, prevent resident falls and to address resident's behaviors. 42360 E. Review of Resident 22's Fall Reviews from 6/11/24 through 10/28/24 revealed the following: -6/11/24 at 1:45 PM the resident was found sitting on the floor of the resident room and reported falling on the way to the bathroom. The intervention was to replace the antiskid strips in the front of the resident's chair, as the resident reported the floor was so slick. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-6/17/24 at 8:20 PM the resident was seen sitting in the doorway of the resident room with pants down around knees, and the resident thought there was smoke in the room. The intervention was to leave the door to the room open for closer monitoring by staff. -6/21/24 at 6:00 AM the resident was found on floor after rolling out of bed and hitting head. The determined cause was falling out of bed. A fall mat was placed beside the bed to protect the resident. -7/5/24 at 8:45 AM the resident was sitting on the floor in front of the recliner and reported I was getting up and fell and thought there was smoke in the room. The intervention was to have the Doctor conduct a medication review. There was no evidence of medication review until 7/11/24 (6 days after the fall) and no evidence a change was made based on the review. -7/15/24 at 7:00 PM the resident was found on the floor. The resident reported walking back from the bathroom and going down to the knees. The resident was independently ambulating without appropriate footwear and appropriate footwear was put on. It was unclear why the resident did not have on appropriate footwear as this was previously implemented. -7/24/24 at 6:15 PM the resident's foot got caught in an overbed table while lifting a recliner footrest. A small abrasion occurred. The bedside table was relocated. There was no evidence where the bedside table was to be located moving forward. -7/27/24 at 6:10 AM the resident was found sitting on the floor. It was determined the resident's motion sensor alarm had been deactivated so the alarm was reactivated. The resident was reminded to use the call light. There was no documentation or investigation to determine why the alarm was not initially activated. -7/29/24 at 6:40 PM the resident was sitting on the floor of the room covered in Bowel Movement (BM) and the resident's ostomy (external exit or artificial opening in which the colon is diverted to the abdominal wall) bag had become loose. The resident did not have their call light and the motion sensor was activated. The intervention was for staff to toilet the resident upon rising, before and after meals and as needed. -8/7/24 at 5:40 PM a Nurse Aide (NA) assisted resident from her recliner to a standing position. The walker wheels were not moving freely, and the resident fell backward onto her buttocks on the floor. The walker was evaluated, and tennis balls were placed on the back legs. -8/9/24 at 5:50 AM staff were assisting the resident to walk from the bathroom and the resident turned too early and missed the chair. Staff lowered resident to the floor. The cause was listed as shoes were not fitting properly. The intervention was to use slipper socks. There was no evidence this was a new intervention as staff were already to be utilizing appropriate footwear. -8/9/24 at 6:40 AM the resident was heard calling for help, found lying face down in the room with blood pooling on the floor from a cut inside the resident's mouth. The resident was reportedly delusional and hallucinating. The Doctor was notified and reviewed resident's condition. As a result, the Resident started on Seroquel (an antipsychotic (class of drugs used to treat symptoms of psychosis)) daily at bedtime. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/17/24 at 2 PM the resident was having increased delusion, hallucinations, and behaviors. A medication audit was completed by the Director of Nursing (DON) and it was determined the resident did not receive the ordered antipsychotic medication Seroquel on 8/9, 8/10, 8/11, 8/14, 8/15, and 8/16. The nurse responsible received disciplinary action. The facility did have evidence of the written warning on 8/19/24 for Registered Nurse (RN)-R. -8/26/24 at 11:00 PM while the resident was being assisted to the bathroom the resident did not turn well enough toward the toilet and sat down on the floor. The intervention was to use a 2 person assist. There was no evidence this was a new intervention, as it had been implemented for a previous fall. -9/28/24 at 6:35 AM The resident was found on the floor beside the bed and reported hearing someone calling the resident's name. The facility determined the resident was delusional. The facility was awaiting an appointment with a psychiatric provider and a scoop mattress was placed on the bed. -9/28/24 at 8:58 PM the resident was found on the floor in front of the recliner, reported putting self-there, and reported that people on the television were calling the residents' name. The television was turned down and resident was assured of safety. -9/28/24 at 9:55 PM the resident was found sitting on the floor of the resident's room scooting self. The resident reportedly slid out of the recliner and reported hiding from people calling out the resident's name on the television. Again, the television volume was turned down and resident was reminded of safety. There was no evidence of new interventions being implemented. -9/29/24 at 5:18 AM the resident was found on the knees beside the recliner. Staff reported a lack of sleep. The facility was awaiting medication review by a psychiatric provided scheduled for 10/7/24. There was no evidence of new interventions being implemented. -9/30/24 at 4:40 PM the resident was found sitting on the floor of the resident room. The resident reported trying to get to the chair. It was determined the residents motion detector was on and working. There was no evidence of new interventions being implemented. -9/30/24 at 7:00 PM the resident was found sitting on the floor beside the recliner. The resident was delusional about a granddaughter needing an ambulance. The facility provided 1:1 (one on one) supervision until the resident settled down and again reported they would await the scheduled mental health provider appointment. There was no evidence of new interventions being implemented. -10/2/24 at 1:15 AM the resident was found sitting on the floor and reported getting up to go to the bathroom but ended up sitting on the floor and scooting to the doorway to get staff's attention. The staff provided assistance to the toilet and provided 1:1 until the resident was settled. There was no evidence of new interventions being implemented. -10/11/24 at 1:12 AM the resident was found sitting on the floor between the bed and small table beside the recliner. The resident continued to have delusions. The facility implemented hourly checks. -10/14/24 at 11:30 PM the resident was reportedly on the floor looking for the baby. The facility reported they were awaiting therapeutic effects from medication changes. There was no evidence of new interventions being implemented. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-10/16/24 at 7:00 AM the resident was found sitting on the floor and reported I didn't fall I scooted out of the chair and over here. The facility indicated they continued to monitor the resident's response to a medication change. There was no evidence of new interventions being implemented. -10/25/24 at 12:06 PM the resident was found sitting on the floor and again reported putting self there. The resident continued to have delusions and hallucinations. The residents' medications had been adjusted and facility was still monitoring for therapeutic effects. There was no evidence of new interventions being implemented. -10/26/24 at 10:05 AM the resident was found lying on the floor and reported left knee pain. The resident continued to have delusions and was assisted to bed for safety. There was no evidence of new interventions being implemented. -10/26/24 at 5:50 PM the resident was found sitting on the floor and reported putting self on the floor due to looking for papers. The resident continued to have delusions and the resident's medication had been recently updated and facility continued to wait on and monitor the therapeutic medication effects. It was also noted that a Mental Health Practitioner had started therapy. There was no evidence of new interventions being implemented. -10/26/24 at 6:40 PM the resident was on the floor again and reported getting on the floor on purpose. The facility implemented 30-minute checks. -10/26/24 at 7:10 PM the resident found on the floor (when staff returned to check after 30 minutes) the resident's room door was left open to allow for additional observation and the resident was left alone to calm self as staff presence was escalating behaviors. Leaving the resident's room door open was not a new intervention. -10/26/24 at 7:25 PM the resident report indicated the resident fell two more times while the nurse was attempting to call the on-call provider to get orders to send the resident to the hospital for evaluation. The resident transferred to the hospital for safety. During an interview on 10/30/24 at 2:48 PM the Director of Nursing (DON) confirmed the facility had not consistently implemented Care Plan interventions to prevent Resident 22 from falling and did not have staff adequate to provide 1:1 supervision for Resident 22, which was indicated to prevent ongoing falls given the resident's delusions/hallucinations and ongoing falls. 51391 F. Review of Resident 3's MDS dated [DATE] indicated the resident was admitted [DATE]. The MDS identified the resident's cognition was severely impaired, with a diagnosis of Non-Traumatic Brain Dysfunction, Non-Alzheimer's Dementia, Depression and Unspecified Dementia, and Unspecified Severity with other Behavioral Disturbance. The resident was frequently incontinent of bowel and bladder, required maximal assistance with toileting hygiene, dressing, and was independent with transfers and ambulation. Observations of Resident 3 on 10/29/24 from 8:10 AM to 2:25 PM revealed the following: (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- 8:10 AM the resident was sitting in the dining room at table eating breakfast, -10:05 AM the resident was sitting up on edge of bed, stood up independently, ambulated to the doorway, looked out into the hall and then ambulated back to bed and laid down, -11:38 AM The resident was lying in bed with eyes closed, -11:55 AM The Administrator woke resident up for dinner, did not offer to assist resident with toileting cares or check for potential incontinence, Administrator walked with resident to the dining room for dinner, -12:40 PM The resident was in the dining room eating dinner independently, and -2:14 PM NA-G assisted the resident to the bathroom, the resident's pull up was heavily soiled with urine. During an interview on 10/29/24 at 2:25 PM, NA-C confirmed Resident 3 was last toileted around 7:00 AM that morning before breakfast and was not toileted again or checked for incontinence until 2:15 PM (7 hours later). NA-C confirmed the resident was to be assisted with toileting cares, with morning cares, before and after meals, in the afternoon and at bedtime. NA-C indicated that toileting cares are difficult to complete on all the residents with the number of staff that was scheduled. G. Review of Resident 6's MDS dated [DATE] indicated the resident was admitted [DATE]. The MDS identified the resident cognition was severely impaired with a diagnosis of Non-Traumatic Brain Dysfunction and Dementia. The resident was frequently incontinent of urine and occasionally incontinent of bowel, required maximal assistance with toilet hygiene, dressing, bed mobility and transfers, and was dependent on staff for wheelchair mobility. Observations of Resident 6 on 10/29/24 from 8:20 AM to 2:00 PM revealed the following: -8:20 AM: the resident was sitting in the dining room at the breakfast table, awake, sipping on water, -10:14 AM: the resident was sitting in recliner with eyes closed cuddling a baby doll, -11:30 AM the resident was sitting in recliner with her eyes closed, -11:55 AM the Administrator pivot transferred the resident into the wheelchair and assisted the resident to the dining room for the dinner meal, -12:30 PM the resident was sitting at the dining room table, eyes closed, a plate of food was on the table untouched, -12:56 PM staff woke the resident up to eat, the resident started eating independently, -1:25 PM the resident was sitting at the dining room table, the resident's plate and glasses were removed from the table, -1:50 PM the resident was assisted out of the dining room to her room, and (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-1:55 PM NA-G and NA-C assisted resident to the bathroom, resident's pull-up was soiled with urine. During an interview on 10/29/24 at 2:05 PM, NA-C confirmed Resident 6 was last toileted at 9:00 AM that morning after breakfast and was not toileted again or checked for incontinence until 2:00 PM (4 hours later). NA-C confirmed that the resident was to be toileted before and after meals, in the afternoon, at bedtime and as needed.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 42360 Licensure Reference Number 175 NAC 12-006.04 Based on observation, record review, and interview; the facility failed to ensure qualified staff were administering oxygen for Resident 4. The sample size was 2 and the facility census was 27. Findings are: Review of the facility Job Description: Certified Nursing Assistant (CNA) with a revision date of 11/15/23 revealed the following: -CNA's played a vital role in providing direct patient care and assisting the nursing and medical staff in delivering high-quality healthcare services. Responsibilities included assisting with dressing, grooming, toileting, feeding, baths/showers, as well as providing basic treatments required and as directed by nursing staff. -Essential job functions included care provision in accordance with resident care plans, recognition of resident needs, and changes in condition and the resulting documentation and reporting requirements. -Nurse Aides (NA's) held current certification and adhered to facility guidelines and policies as well as State Regulations. -There was no evidence NA's were qualified or responsible for Administration or Provision of Medications or Oxygen. During an observation of the provision of care for Resident 4 on 10/29/24 at 1:32 PM, NA-C put on a gown in the hall and entered the resident room, performed hand hygiene, and put on disposable gloves. The resident was seated in a wheelchair. After assisting the resident to the toilet and back to a recliner NA-C turned on the resident oxygen concentrator and placed a nasal cannula (tube placed in the resident's nose used to deliver oxygen) on the resident. During an interview on 10/29/24 at 1:37 PM NA-C confirmed she was a NA and although having a Medication Aide Certification in Minnesota she was not certified in Nebraska and would have to retest to become certified. During an interview on 10/3/24 at 2:27 PM the Director of Nursing (DON) confirmed NA-C was a NA and not a Medication Aide (MA) and was not qualified to administer and or interrupt the flow of oxygen, or qualified/trained to do so.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.10(D) Based on observation, interview, and record review; the facility failed to ensure a medication error rate of less than 5%. There were 25 opportunities of medication administration observed with 2 errors resulting in error rate of 8%. The sample size was 5 and the facility census was 26. Findings are: A. Review of the facility policy Medication Administration with a revision date of [DATE] revealed the following: -Medications were administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. -Personnel authorized to administer medications do so only after they have been authorized to administer medications, and do so only after they had been properly oriented to the facilities medication distribution system. -The facility had sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. -Medications were prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications. -Person's administering medications adhered to good hand hygiene, which included washing hands thoroughly. -Before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident, before and after administration of ophthalmic (eye), topical, vaginal, rectal, and parenteral (through the veins) preparations, and before and after administration of enteral (directly administered in the gastrointestinal tract) medications. -Examination gloves were worn when necessary. -Hand sanitation was completed with an approved sanitizer, at regular intervals during the medication pass such as after each room. -Medications were administered according to the 5 Rights (Right Resident, Right Drug, Right Dose, Right Route, and Right Time) and applied to each medication being administered. -The Medication Administration Record (MAR) was always employed during medication administration and compared to the medication label. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Review of Resident 2's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident care plans) dated 9/18/24 revealed the following: -The resident had diabetes, impaired motion to all 4 extremities and was dependent for all hygiene, dressing, transfers, and toileting, and -received insulin injections daily. Review of Resident 2's Care Plan with a revision date of 10/10/24 revealed the following: -The resident had diabetes and was on routine sliding scale (insulin administered based on the results of blood glucose levels) insulin to control blood sugar. -Staff were to monitor blood glucose levels as ordered by the physician, and provide medication as ordered. Review of Resident 2's Physician's orders on the Treatment Administration Record (TAR) date October 2024 revealed the resident was to have Fiasp Injection per sliding scale: if 70-150 give 0 units, 151-200 give 3 units, 201-250 give 6 units, 251-300 give 9 units, 301-350 give 12 units, 351-400 give 15 units, and 401-450 give 18 units, if greater than 450 contact the doctor. During an observation of the provision of medications on 10/29/24 at 12:08 PM Licensed Practical Nurse (LPN)-H prepared to administer a dose of short acting insulin (Fiasp) to Resident 2. LPN-H after checking the resident blood glucose (result 203), went to the utility/med room and proceeded to obtain insulin bottle from the cupboard, looked at a type written noted for Resident 2 that was stored in an equipment caddy in the medication room and contained sliding scale insulin instructions that indicated the resident was to have 6 units for blood glucose levels between 201-250. The LPN (without checking the Medication Administration Record (MAR)) then withdrew 3 units of the insulin into a syringe from the vial, proceeded to the resident's room, put on gloves, and prepared to give the 3 units of insulin. The surveyor questioned if the LPN-H was going to give the insulin and the LPN-H affirmed that. The Surveyor then asked the LPN to proceed to the MAR, located in the nurse's office and recheck the resident's order. LPN-H did so and identified that after entering the resident's blood glucose results of 203 into the MAR the correct dose of insulin to be given was 6 units. LPN-H then discarded the previous syringe of insulin into a sharps container (used to dispose of items such as used needles or other sharp medical devices) in the medication room and then withdrew 6 units of Fiasp insulin from the vial, and proceeded to the resident's room. The insulin injection was then given. During an interview on 10/29/24 at 12:15 PM LPN-H confirmed had the surveyor not intervened, the LPN would have given 3 units rather than 6 units of the insulin (Fiasp). Further interview confirmed had LPN-H entered the blood glucose results into the computer MAR, prior to preparing the resident's insulin dose the computer would have calculated and instructed the person administering the insulin of the proper dose to administered. LPN-H confirmed the LPN had not followed facility policy and 5 rights of medication administration. C. Review of Resident 10's MAR dated October 2024 revealed an order for Miralax (powdered laxative used to prevent constipation and mixed into liquid for drinking) 17 GM (grams) give 8.5 grams by mouth one time daily. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of the provision of medications for Resident 10 on 10/29/24 at 8:35 AM MA-K measured out 8.5 grams of Miralax mixed it into a glass of fluid and took it to the resident while sitting in the dining room for breakfast. The resident took pills that were provided, however the MA walked away and did not ensure the resident consumed the glass of Miralax. The MA then returned to the medication cart and signed off the Miralax as given, however it had not been consumed. D. During an interview on 10/30/24 at 3:46 PM the Director of Nursing (DON) confirmed that staff were to witness the complete consumption of all medications, including those medication mixed in fluids. In addition, insulin given by sliding scale must be based on the results of the residents' blood glucose levels, and the MAR should always be utilized during medication administration to ensure the 5 rights of medication administration were accurately followed, to prevent medication errors.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.04(H)(ii)(2) Based on record review and interview; the facility failed to ensure the Dietary Manager (DM) had the credentialing to meet regulatory requirements for the position. This had the potential to affect food service provided to 26 residents who were served food from the kitchen. The total sample size was 22 and the facility census was 26. Findings are: Review of the facility Job Description: Director of Dining Services revised 7/18/24 revealed the DM would perform the assigned duties in accordance with current federal and state regulations. The DM would meet current requirements established by the regulatory agencies or be enrolled in a class to meet such requirements. Record review of the DM's personnel file revealed no evidence that the DM completed the required training. Interview with the DM on 10/28/25 at 9:00 AM revealed the DM did not have the education, credentialing or certification required for the position of DM. The DM confirmed enrollment in a class/course to obtain the required education and credentials. The DM indicated the Registered Dietician came to the facility every other week and there was no additional staff employed at the facility with the required qualifications.

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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. 29638 Licensure Reference Number: 175 NAC 12-006.11E Based on observations, record review and interviews; the facility failed to maintain kitchen sanitation and to store and serve food in a manner to prevent potential foodborne illness. This had the potential to affect 26 residents in the facility that ate food stored and prepared in the facility kitchen. The facility census was 26. Findings are: A. Review of the facility policy Bare Hand Contact with Food and Use of Plastic Gloves (undated) revealed single use gloves were to be worn when handling food directly with hands to assure that bacteria were not transferred from the food handlers' hands to the food product being served. Gloves were considered just like hands. Anytime a contaminated surface was touched, the gloves were to be changed, and hands were to be washed. Bare hand contact with food was prohibited. In addition, the policy indicated staff were to use good hygiene practices and techniques with access to proper hand washing facilities. Antimicrobial or antiseptic gel was not to be used in place of proper hand washing. B. Observation of food service for the noon meal on 10/29/24 from 11:50 AM to 12:10 PM revealed Dietary [NAME] (DC)-J failed to wash hands with soap and water and completed hand hygiene with use of hand sanitizer. DC-J proceeded to use bare hands to pick up slices of bread, buttered the bread and placed on the cooking surface of the grill. DC-J then used bare hands to place 2 slices of cheese on each of the pieces of buttered bread followed by a second slice of buttered bread. DC-J continued this process until interrupted by the Dietary Manage (DM). DC-J again used the hand sanitizer and then placed on a pair of disposable gloves. DC-J used gloved hands to butter the bread slices and to place cheese on the bread. While continuing to make the sandwiches, DC-J used gloved hands to adjust the knobs on the stove, to open drawers and to handle various kitchen utensils. C. Observations during the follow-up kitchen sanitation tour on 10/29/24 from 12:15 PM to 12:46 PM with the DM revealed the following: -plastic scoops were observed inside of the flour and the sugar bins with the handles touching the food products. -a box fan in a storage area with disposable food containers and 2 chest freezers had blades which were coated with a dark gray fuzzy substance that resembled dust. The fan was running and blew over the storage area. -chest freezer with have an accumulation of frost and frozen condensation droplets on the roof and a large accumulation of ice to the sides of the unit. -repackaged plastic bags in the chest freezer which contained what appeared to be unbaked cinnamon rolls, donut holes and pork tenderloins which were not labeled and/or dated as to when re-packaged. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-heavy layer of food splatter to the top and sides of a microwave. -ice machine positioned in the kitchen with a heavy layer of dust/debris to the outside of the filter storage area. In addition, a heavy build-up of lime deposit was observed to the exterior of the machine and to the grate over the ice storage bin with a constant drainage of ice/water noted into the bin even when the machine was not in use. D. Review of the facility Kitchen Cleaning Checklist (undated) revealed daily on both the AM and the PM shift the staff were to clean the inside and the outside of the microwave and monthly were to clean the fans in the kitchen and the food storage areas. E. During an interview on 10/29/24 at 2:03 PM, the DM and the Administrator confirmed the following: -scoops should not have been left inside of the flour and the sugar bins. -fans in the kitchen needed to be cleaned. -frozen food which had been removed from their original packaging should have been labeled and dated as to when placed in new packaging. -DC-J should not have used hand sanitizer in the kitchen but should have washed hands. -DC-J should not have used bare hands to touch food items and should not have used gloved hands to touch food items and then used the same gloved hands to touch other items in the kitchen before returning to use handling food. -ice machine should have been clean and disinfected. -microwave should have been cleaned when soiled with food and before continued use. -the facility had a list of cleaning duties but there was no evidence cleaning had been completed. F. Review of the 7/21/2016 version of the Food Code, based on the United States Food and Drug Administration Food Code and used as an authoritative reference for food service sanitation practices, revealed the following: -2-301.14 Food employees shall wash hands and exposed portions of their arms immediately before engaging in food preparation; after handling soiled equipment; and before donning gloves to work with food. -3-304.15 (A) Single use gloves shall be used for only one task and should be discarded when soiled or when interruptions occur in the operation. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-4-602.12 revealed that non-food contact surfaces of equipment shall be cleaned at a frequency necessary to prevent the accumulation of soil residues.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER: 175 NAC 12-006.18 Based on observations, interviews, and record reviews; the facility failed to prevent potential cross contamination related to 1) completion of hand hygiene and changing of gloves during the provision of cares for Residents 7, 11, 3, 6, 22, 8, 1, 2 and 21 and during the administration of medications for Resident 2; 2) cleaning a sit-to-stand mechanical lift (devices used to transfer residents) between resident uses for Residents 7, 8, 13 and 78; and 3) implementation of enhanced barrier precautions for Resident 2. The total sample size was 22 and the facility census was 26. Findings are: A. Review of the facility policy Standard Precautions updated on 9/6/24 revealed the following: 1) Staff were to perform hand hygiene: -after touching blood, body fluids, secretions, and contaminated items. -prior to putting on gloves and immediately after removing gloves. -before direct contact with patients. -when moving from a contaminated body site to a clean body site. 2) Staff were to wear gloves when touching blood, body fluids, secretions, excretions, and contaminated items. Staff were to remove gloves promptly and wash hands after use and before touching non-contaminated items and environmental surfaces and before going to another resident. 3) Staff were to clean reusable resident-care equipment between uses to prevent the transmission of microorganisms to other residents and environments. B. During an observation on 10/29/24 at 10:33 AM, Nursing Assistant (NA)-C and NA-G provided toileting and incontinence care for Resident 7. NA-C and NA-G entered the resident's room and without washing hands or completing hand hygiene transferred the resident from the wheelchair to the toilet using the mechanical lift. NA-C still without completing hand hygiene placed on one disposable glove and removed the resident's incontinent brief which was soiled with urine and feces. After discarding the soiled brief, NA-C placed on a second glove. NA-C provided perineal hygiene but failed to remove soiled gloves. While still wearing the soiled gloves, NA-C placed a clean incontinence brief on the resident, adjusted the resident's clothing, assisted with the transfer of Resident 7 from the toilet to the recliner in the resident's room, disconnected the sling from the lift, removed it from behind the resident's back, adjusted the resident's shirt and the resident's positioning in the recliner. NA-C then removed soiled gloves and positioned the mechanical lift against the wall. NA-C and NA-G exited the resident's room without cleansing/disinfecting the lift and without washing hands or completing hand hygiene. (continued on next page)

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	285180	A. Building B. Wing	10/31/2024

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Butte Senior Living	210 Broadway Butte, NE 68722

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 10/29/24 at 11:05 AM, NA-C confirmed failure to wash hands or to use hand sanitizer when entering the resident's room for cares, when removing soiled gloves and when exiting the resident's room. NA-C also confirmed staff did not clean/disinfect the mechanical lift and further confirmed the lift was used for other residents and should be cleaned after use for each resident. C. Observation of toileting cares for Resident 11 on 10/29/24 from 4:35 PM to 5:10 PM revealed NA-C assisted the resident to the resident's room. Without washing hands or performing hand hygiene, NA-C placed on clean gloves and transferred the resident from the wheelchair and into the bathroom. NA-C removed the resident's disposable incontinent brief which was heavily saturated with urine and then removed soiled gloves and washed hands. NA-C placed on clean gloves and provided the resident with incontinence cares, then applied a layer of barrier cream with the same pair of gloves directly to the resident's buttocks. Without removing soiled gloves, NA-C placed a clean incontinence brief on the resident, adjusted the resident's clothing and transferred the resident back into the wheelchair. NA-C removed the gait belt from the resident and positioned the foot pedals back onto the wheelchair before removing soiled gloves and washing hands. D. During an interview on 10/30/24 at 4:09 PM, the Director of Nursing (DON) and the Administrator confirmed the following: -staff were to wash hands or to perform hand hygiene when entering a resident's room, before putting on clean gloves and when taking off soiled gloves. -gloves were to be worn when providing toileting and incontinence cares for the residents and should be changed when going from a dirty task to a clean task. -the sit-to-stand mechanical lift was routinely used to transfers 4 residents (Residents 7, 78, 8 and 13). The lift was to be cleaned and disinfected after each resident use. 51391 E. During an observation on 10/29/24 at 1:55 PM, NA-C and NA-G provided toileting and incontinence care for Resident 6. NA-C and NA-G entered the resident's room and failed to complete hand hygiene before placing on clean disposable gloves. NA-C assisted the resident into the bathroom. The resident was stood, and NA-G removed the resident's disposable pull-up which was soiled with urine and as the pull-up was removed, the resident began to urinate on the floor. The resident was transferred onto the toilet. NA-C removed gloves, failed to complete hand hygiene and without gloves. NA-G cleaned urine from the bathroom floor and removed soiled gloves, then used a pre-moistened disinfectant wipe to clean urine from the resident's wheelchair cushion. Without washing hands, both staff put on clean gloves and assisted the resident to stand. NA-C completed perineal hygiene. Without removing the soiled gloves, the staff placed on a clean incontinence pull-up, adjusted the resident's clothing, and transferred the resident into the wheelchair. Staff removed their soiled gloves, transferred the resident into a recliner and exited the resident's room without completing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F. During an observation on 10/29/24 at 2:14 PM, NA-C provided toileting and incontinence cares for Resident 3. NA-C entered the resident's room, and without completing hand hygiene, assisted the resident into the bathroom. NA-C put on clean gloves and assisted to remove the resident's disposable incontinent brief which was soiled with urine. NA-C removed soiled gloves, but failed to complete hand hygiene, before putting on a clean pair of gloves. A clean incontinent brief was placed on the resident, peri cares were completed, and the resident's brief and pants were adjusted. NA-C removed gloves and assisted the resident back to bed. NA-C picked up the trash and removed from the room without completing and hand hygiene. G. During an interview with NA-C on 10/29/24 at 2:25 PM, NA-C confirmed no hand hygiene was completed prior to entering the resident's rooms, before cares were initiated, when gloves were changed with cares and after completing cares for Residents 3 and 6. 42360 H. During an observation of the provision of medication administration for Resident 2 on 10/29/24 at 12:08 PM Licensed Practical Nurse (LPN)-H prepared 6 units of Fiasp (insulin), went to Resident 2's room, put on disposable gloves without performing hand hygiene, administered the insulin into the resident's abdomen. LPN-H then exited the resident room still wearing the gloves, proceeded to, and unlocked the door to the medication room, discarded the used syringe, opened the cupboard door, and put the caddy of insulin back into the cupboard. LPN-H then removed the gloves, did not hand sanitize and went to the computer, signed off the medication and then hand sanitized. I. During an observation of the provision of care for Resident 4 on 10/29/24 at 1:32 PM Nurse Aide (NA)-C put on a gown and entered the resident's room, performed hand hygiene, and put on disposable gloves. NA-C assisted the resident to the bathroom for toileting and after the resident was done retrieved pre-moistened wipes and performed perineal hygiene. Then while wearing the same gloves pulled up the resident's incontinence brief and pants and transferred resident back to wheelchair. Again, while using the same gloves NA-C assisted the resident to transfer to a recliner chair, moved the w/c and covered the resident with a blanket, removed the gloves and gown and did not perform hand hygiene. NA-C exited the room with linens and trash and did not perform hand hygiene. J. During an observation of the provision of care for Resident 22 on 10/31/24 at 8:50 AM Medication Aide (MA)-L and Licensed Practical Nurse (LPN)-P transferred the resident from a geri-chair (reclining wheelchair) to a recliner with extensive assist of 2 staff and the use of a gait belt (belt placed around the residents waste used to steady the resident and provide safety for the staff and resident during a transfer). Staff assured resident was safe, exited room, proceeded down the hall and did not perform hand hygiene. K. During an observation of the provision of care for Resident 8 on 10/29/24 at 1:01 PM NA-C and MA-G entered the resident's room and did not perform hand hygiene. MA-G put on a pair of disposable gloves and NA-C did not. NA-C and MA-G then secured the resident in a mechanical stand-up lift and lifted the resident into a standing position. MA-G pulled down the resident's pants and removed the resident's incontinence brief, performed perineal care using a disposable wipe. MA-G then pulled up the resident's clean brief and pants and using the lift transferred the resident to the bed, positioned the resident in bed, covered with a blanket and gave the resident a call light all with the same gloves used to perform peri-cares. MA-G then gathered the trash and linen, removed the gloves, and exited the room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	L. During an interview on 10/30/24 at 3:58 PM the Director of Nursing (DON) confirmed staff are to perform hand hygiene with each glove change, glove changes are to be completed when going from a dirty to a clean task and before and after personal care provision for each resident. In addition, the staff are to perform hand hygiene before and after care provision for each resident. Further interview confirmed staff should remove gloves and hand sanitize after giving resident injections and prior to handling other items such as door handles, cupboards, and the computer keyboard. 45739 M. Review of the facility policy Enhanced Barrier Precautions last updated 9/6/24 revealed the following: -Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of Multi-Drug-Resistant Organisms (MDRO) that utilizes gown and glove use during high contact resident care activities, -an order for EBP would be obtained for residents with wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO, or had an infection or colonization with a Centers for Disease Control (CDC)-targeted MDRO, -Personal Protective Equipment (PPE) for EBP was only necessary when performing high-contact care activities, -the infection preventionist would incorporate periodic monitoring and assessment of adherence to determine the need for additional training, -High-contact resident care activities included: dressing, transferring, providing hygiene, changing briefs or linens, toileting assistance, and wound care, -important MDRO's may include but are not limited to Methicillin- resistant Staphylococcus Aureus (MRSA) and Vancomycin-resistant Enterococci (VRE), and -EBP should be used for the duration of the affected residents stay in the facility or until resolution of what puts the resident at higher risk. N. Review of Resident 1's MDS dated [DATE] revealed the resident was cognitively intact and required assistance with toileting, dressing, transfers, and mobility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 10/30/24 at 1:05 PM NA-C assisted Resident 1 from the hallway into the resident bathroom. NA-C put on a pair of gloves without performing hand hygiene, assisted the resident to stand and pivot to the toilet, then NA-C pulled the resident's pants and brief down. The resident sat on the toilet and NA-C removed the residents soiled brief. NA-C still wearing the dirty gloves moved the resident's wheelchair next to the resident then removed their gloves and no hand hygiene was observed to be completed. When Resident 1 was finished on the toilet, NA-C put on a new pair of gloves, moved the resident's wheelchair away from the resident and applied a clean brief to the resident. NA-C assisted the resident to standing position, the resident had a bowel movement (BM) and NA-C performed peri cares. NA-C continued to wear the same pair of soiled gloves, pulled the residents brief, and pants up, then moved the wheelchair next to the resident again while still wearing the same pair of gloves. NA-C while continuing to wear the soiled pair of gloves assisted Resident 1 to transfer to the wheelchair. NA-C used pre-moistened wet wipes to wipe BM off the toilet seat. While continuing to wear the soiled gloves, NA-C moved the resident from the bathroom to next to the resident bed. NA-C while continuing to wear the same pair of gloves, transferred Resident 1 into the bed. NA-C removed their soiled gloves, no hand hygiene was observed to be performed, obtained the trash from the resident bathroom, and exited the resident room. No hand hygiene was observed to be completed. O. Review of Resident 2's MDS dated [DATE] revealed the resident was cognitively intact and was dependent with toileting, dressing, transfers, and mobility. Review of Resident 2's Care Plan last revised 10/10/24 revealed the resident had a history of MRSA and no documentation the resident had EBP implemented. The following observations were made related to Resident 2: -on 10/29/24 at 9:38 AM there was no sign posted or visible isolation supplies for EBP, -on 10/29/24 at 1145 with MA-G and NA-C entered the resident room and put on gloves without performing hand hygiene. NA-C uncovered Resident 2 and cleansed the abdominal folds but needed more wipes. NA-C removed their gloves and exited the room, and no hand hygiene was observed. NA-C returned and applied new gloves without performing hand hygiene. NA-C performed peri cares on the resident, and still wearing the same gloves, applied a clean brief. Continuing to wear the same pair of gloves, the aides rolled the resident to pull up the resident's clothes and apply the lift pad under the resident. NA-C still wearing the same pair of gloves hooked the resident up to the full body lift and NA-C removed their gloves. No hand hygiene was observed. The resident was transferred to the wheelchair, was assisted to be comfortable and given their call light, then MA-G gathered the trash and removed their gloves. No hand hygiene was observed, and MA-G and NA-C left the resident room. The trash was disposed of in the appropriate receptacle and no hand hygiene was observed to be completed by either aide. -On 10/30/24 at 7:35 AM There was no evidence the resident had EBP implemented. -On 10/31/24 at 7:45 AM There was no evidence the resident had EBP implemented. Interview on 10/31/24 at 8:40 AM with the DON confirmed Resident 2 was not on EBP but should have been due to the resident's history of MRSA. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	P. Review of Resident 21's MDS dated [DATE] revealed the resident had severe cognitive impairment and required assistance with dressing and toileting. An observation on 10/29/24 at 12:05 PM NA-G entered the resident room and assisted Resident 21 into the bathroom. NA-G applied gloves without performing hand hygiene, assisted the resident to pull their pants and brief down and the resident sat on the toilet. NA-G while wearing the same pair of gloves turned on the water faucet and removed their gloves. When the resident was finished, NA-G turned the water faucet off and put on gloves without performing hand hygiene. NA-G performed peri cares on the resident. Still wearing the same pair of gloves, NA-G pulled the residents brief then pants up and touched the resident on the arm. NA-G removed their gloves and no hand hygiene was observed to be completed. NA-G assisted the resident out of the bathroom, exited the resident room, and ambulated up the hallway passing mounted hand sanitizer in the hallway to the dining room. No hand hygiene was observed to be completed. Q. Interview on 10/30/24 at 4:20 PM with the DON and the Administrator confirmed hand hygiene should be performed before resident cares, with glove changes, after resident cares and when exiting the resident room.