

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  285201	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  05/14/2024
NAME OF PROVIDER OR SUPPLIER  Cloverlodge Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  301 North 13th Street St Edward, NE 68660	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>29638</p> <p>Licensure Reference Number 175 NAC 12-006.02(1)</p> <p>Based on record review and interview, the facility failed to submit transfer and discharge notifications to the State Ombudsman (an official appointed to investigate individuals' complaints and serves as a consumer advocate) as required for 1 (Resident 34) of 1 sampled resident. The facility census was 33.</p> <p>Findings are:</p> <p>Review of the Resident 34's Nursing Progress Notes revealed the resident was transferred and admitted to the hospital on 12/8/23, 2/1/24 and again on 4/16/24.</p> <p>During an interview on 5/9/24 at 11:08 AM, the Social Service Director (SSD) and the Administrator confirmed the facility had no documented evidence the State Ombudsman was notified of Resident 34's hospital discharges.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0625</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.</p> <p>29638</p> <p>Licensure Reference Number 175 NAC 12-006.05(1)</p> <p>Based on record review and interview, the facility failed to provide Resident 34 or the resident's representative, bed hold information when the resident was transferred to the hospital. The sample size was 1 and the facility census was 33.</p> <p>Findings are:</p> <p>Review of the undated facility Notice of Bed Hold Policy revealed the facility advised the resident and or family of the bed hold policy, in writing and when possible, within 24 hours of an emergency transfer to inform them of the bed hold rate (daily cost/rate for the type of room being held for the resident).</p> <p>Review of Resident 34's Nursing Progress Notes revealed the resident was transferred to the hospital on 2/1/24.</p> <p>Review of Resident 34's medical record from 2/1/24 through 3/1/24 revealed no evidence the resident or the resident's representative were notified of the facility bed hold policy when Resident 34 was transferred to the hospital on 2/1/24.</p> <p>During an interview on 5/9/24 at 11:08 AM, the Social Service Director (SSD) and the Administrator confirmed the facility had no documented evidence Resident 34 or their representative were provided with the required bed hold information when discharged to the hospital on 2/1/24.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 29638</p> <p>LICENSURE REFERENCE NUMBER 175 NAC 12-006.18E1</p> <p>Based on observations, record review and interviews; staff failed to utilize a full body lift (device that allows residents to be transferred between 2 surfaces using hydraulic power and requires no weight bearing assistance from the resident) and a sit-to-stand mechanical lift (mobile lift that allows for resident transfer from a seated to a standing position) in a manner to prevent potential accidents for 2 (Residents 9 and 34) of 4 sampled residents. The facility census was 33.</p> <p>Findings are:</p> <p>A. Review of a Lift and Transfer Program Policy dated 2/19 revealed that 2 team members were required to be involved with the entire process of assisting a resident and operating a full body lift.</p> <p>B. Review of Resident 9's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 4/3/24 revealed diagnoses of non-traumatic brain dysfunction, heart failure, arthritis, and dementia. The assessment indicated the resident's cognition was severely impaired, the resident was dependent for transfers, dressing, bed mobility, and toileting hygiene, and the resident was always incontinent of bowel and bladder.</p> <p>Review of Resident 9's current Care Plan with a revision date of 1/4/24 revealed the resident was to have total assist of 2 staff for transfers with the full body lift.</p> <p>During an observation on 5/9/24 at 1:23 PM, Nurse Aide (NA)-H used the full body lift to transfer the resident from the wheelchair to the bed. NA-H attached the lift sling which was positioned underneath of the resident to the lift and used the hand control to raise the resident out of the wheelchair. NA-H physically maneuvered the lift close to the resident's bed and while continuing to use the hand control manipulated the resident's body over the bed and lowered the resident onto the bed. NA-H did not have assistance from another staff member with this transfer but completed the transfer independently.</p> <p>During an interview on 5/9/24 at 2:45 PM, the Director of Nursing and the Administrator verified NA-H should not have transferred Resident 9 independently and 2 staff should be utilized with all full body lift transfers to prevent potential injuries or falls.</p> <p>C. Review of a Sit-to Stand Competency form completed by NA-H on 3/10/24 revealed the following procedure for use of the sit-to-stand lift:</p> <ul style="list-style-type: none"> <li>-identify the correct lift and harness by checking source that designates the resident's mechanical lift needs,</li> <li>-inspect the lift and harness for safe use,</li> <li>-explain lift procedure to the resident and lock wheels of bed or chair,</li> </ul> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-begin with the resident seated. If in bed, raise the back of the bed and then assist resident to dangling position,</p> <p>-position the harness around the resident's upper body at least 2-3 inches below the under arm,</p> <p>-position the resident's arms outside the harness,</p> <p>-fasten the safety belt around the resident's waist/pelvis,</p> <p>-position the lift in front of the resident opening the legs of the lift with the leg spreader bar if necessary to fit around furniture. Assist the resident to place feet squarely on the footrest,</p> <p>-carefully advance the lift toward the resident, until shins rest against the shin pad if possible. Fasten shins with the shin strap to keep shins and feet in place. Shin rest should be below the resident's knees for comfort. Adjust as needed,</p> <p>-fasten the loops of the harness to the lift arm hooks using the shortest loops possible. Use the same loop on both sides. Instruct the resident to hold the padded handles with both hands if able,</p> <p>-while raising the resident up, be sure to grasp the loose end of the waist strap and tighten as the resident is raised. Gently keep the slack removed from the belt throughout the process,</p> <p>-using the up button on the hand control, slowly raise the resident to a standing. The resident should be encouraged to bear weight as they are lifted and lean back if possible, and</p> <p>-transfer the resident to the desired location.</p> <p>D. Review of Resident 34's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of dementia, Alzheimer's disease, anemia, end stage renal disease, and urinary tract infection in the last 30 days. The resident was assessed with severe cognitive impairment; required substantial to maximal staff assistance with dressing, personal hygiene, and transfers; required total assistance with toileting; and had an indwelling urinary catheter.</p> <p>Review of Resident 34's current Care Plan with a revision date of 12/11/23 revealed the resident was to be transferred with 1 staff assist using the sit-to-stand mechanical lift.</p> <p>During an observation on 5/13/24 at 10:46 AM, NA-H transferred Resident 34 out of the wheelchair and onto the bed with the sit-to-stand lift. NA-H placed and secured the harness around the resident's upper body. NA-H assisted to place the resident's feet on the footrest of the lift and placed the resident's shins against the shin pad. However, NA-H failed to secure the resident's lower legs with the shin strap before standing the resident up from the wheelchair and transferring the resident onto the bed.</p> <p>During an interview on 5/13/24 at 11:06 AM, NA-H confirmed staff had been trained to secure the resident's lower legs with the shin strap of the sit-to-stand lift but indicated the resident's room was too crowded to secure the resident's legs.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with the DON on 5/13/24 at 12:26 PM verified NA-H should have assured Resident 34's lower legs were secured to the shin pad of the mechanical lift before transferring the resident to promote the resident's safety.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42360</p> <p>Licensure Reference Number 175 NAC 12-006.11E</p> <p>Based on observation and interview; the facility failed to implement and maintain a cleaning schedule for kitchen items and equipment to prevent the potential for food borne illness. This had the potential to affect all facility residents. The facility census was 33.</p> <p>Findings are:</p> <p>The following concerns were identified during the follow up kitchen tour on 5/13/24 from 11:40 AM through 12:05 PM:</p> <ul style="list-style-type: none"> <li>-a thick layer of black burnt on grease was noted on the inside surface and back surface of the grill attached to the oven and the inside surfaces of the oven especially around the doors were also covered with burnt on food residue; The outside surface of the oven also had areas of food residue, and the floor beneath the oven had grease and food debris visible.</li> <li>-The walk-in refrigerator had food residue running down the outside surface of the refrigerator below the access doors and next to the walk-in door where the garbage cans were located.</li> <li>-The reach-in refrigerator in the dry storage area had a very soiled handle and the surrounding surface area around the handle was also soiled.</li> <li>-The facility toaster was also coated with burnt on grease and covered in breadcrumbs inside and below the toaster on the stainless-steel cabinet it was sitting on.</li> <li>-The wall behind the steam table (used to keep prepared food warm during meal service) was soiled with food debris.</li> <li>-The microwave oven had spattered food present inside that had not been cleaned after use.</li> <li>-The food serving cart used to take food items to residents had wheels that were covered in dirt and debris and had food residue and crumbs in all the corners of all 3 shelves.</li> <li>- The floor just underneath and below the cupboards in the snack and serving area adjacent to the kitchen also had dirt and debris on the floors and one cupboard door was chipped and peeling and was not a cleanable surface.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on 5/14/24 at 10:02 AM The Food Services Supervisor (FSS) confirmed the facility had not implemented and maintained a cleaning schedule for kitchen items and equipment such as the ovens, the stove top grill, the floor under the oven, a gray storage cabinet beneath a food preparation area, the outsides of the sugar and flour bins beneath the food preparation area, the outside walls of both the walk in and the reach in refrigerators, the toaster and the area beneath the toaster, the microwave, and the wall directly behind the steam table in which the prepared food was served from were not on a routine cleaning schedule. In addition, the FSS confirmed the facility had no evidence they were cleaning kitchen items/equipment on a routine schedule and did not have a policy for kitchen sanitation.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 42360</p> <p>Licensure Reference Number 175 NAC 12-006.17</p> <p>Based on observations, record review and interview; the facility failed to implement hand hygiene measures to prevent the potential spread of infection for Resident 5 and failed to wear the required Personal Protective Equipment (PPE) when providing management/care of Resident 34's catheter. The sample size was 14 and the facility census was 33.</p> <p>Findings are:</p> <p>A. Review of the undated facility policy Infection Prevention and Control Program revealed the facility developed and maintained an infection prevention and control program that provided a safe, sanitary, and comfortable environment to help prevent the development and transmission of infection.</p> <p>B. Review of the undated facility policy Standard Precautions revealed the following:</p> <p>-team members followed accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions (precautions used during the provision of all care, established to prevent infection and or the spread of infection), and</p> <p>-hand hygiene would be done, for a minimum of 20 seconds, before and after all patient care and after removing and disposing of gloves and other protective equipment.</p> <p>C. Review of Resident 5's Minimum Data Set (MDS-federally mandated comprehensive assessment used to develop resident Care Plans) dated 4/3/24 revealed the following;</p> <p>-the resident had severe cognitive impairment and dementia,</p> <p>-was incontinent of bladder, and</p> <p>-received substantial assistance with transfers, toileting, and toileting hygiene.</p> <p>During an Observation of care for Resident 5 on 5/13/24 at 9:51 AM, Nurse Aide (NA)-H entered Resident 5's room. NA-H did not perform hand hygiene (wash hands or sanitize). NA-H put on gloves and assisted the resident from a wheelchair to the bathroom using a stand-up mechanical lift. NA-H pulled down the resident pants and incontinence brief and then using the mechanical lift sat the resident on the toilet. After going to the bathroom NA-H assisted the resident to stand, assisted the resident with toileting hygiene and pulled up the brief and pants. NA-H then removed the gloves but did not perform hand hygiene. The resident was then assisted back into the wheelchair and positioned for comfort. NA-H exited the room and did not perform hand hygiene.</p> <p>D. During an interview on 5/13/24 at 1:55 PM, Licensed Practical Nurse/Infection Preventionist (LPN/IP) revealed staff are to perform hand hygiene prior to administering care, each time gloves are changed and after completing care to prevent the potential spread of infection.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>29638</p> <p>E. Review of the facility policy for Enhanced Barrier Precautions (EBP-use of PPE to reduce the transmission of multi drug-resistant organisms (MDRO- organisms resistant to at least one or more classes of antimicrobial agents) between residents) dated 4/12/24 revealed EBP was to be initiated on residents with any of the following:</p> <ul style="list-style-type: none"> <li>-chronic wounds such as pressure injuries, diabetic foot ulcers, or venous stasis ulcers (non-healing wound around the ankle and lower legs caused by blood flow problems),</li> <li>-indwelling medical devices such as central lines, urinary catheters, feeding tubes and tracheostomy tubes, and</li> <li>-surgical wounds that have drains (device to remove fluid as it collects), a recent dehiscence (closed incision which re-opens either internally or externally), have been left open to heal or shows signs of infection.</li> </ul> <p>The policy further revealed use of PPE would be required with high-contact resident care activities such as dressing, bathing, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use and wound care.</p> <p>F. Review of Resident 34's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of dementia, Alzheimer's disease, anemia, end stage renal disease, and urinary tract infection in the last 30 days. The resident was assessed with severe cognitive impairment; required substantial to maximal staff assistance with dressing, personal hygiene, and transfers; required total assistance with toileting; and had an indwelling urinary catheter.</p> <p>Observations of cares completed on 5/13/24 at 10:46 AM by NA-H revealed the following:</p> <ul style="list-style-type: none"> <li>-entered the resident's room, washed hands, and placed on a clean disposable gown, a pair of disposable gloves and goggles,</li> <li>-emptied the resident's urinary catheter drainage bag and removed disposable gloves,</li> <li>-without washing hands or performing hand hygiene, transferred the resident onto the bed and laid the resident on their back,</li> <li>-without use of gloves, NA-H lowered the resident's slacks and grabbed the uncovered catheter drainage bag, pulled the bag through the left leg and out the top of the slacks,</li> <li>-still without use of gloves, continued to hold the catheter drainage bag and ran the bag down the top of the resident's slacks and out the bottom of the right pant leg,</li> <li>-secured the catheter tubing to a catheter secure band on the upper right thigh,</li> <li>- adjusted the resident's slacks, covered with a blanket, and attached the call light to the blanket, and</li> </ul> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-finally washed hands before exiting the resident's room.</p> <p>During interviews on 5/13/24 from 11:06 AM to 12:26 PM, NA-H and the Director of Nursing (DON) confirmed NA-H should have been wearing gloves when handling Resident 34's urinary catheter drainage bag as the resident was on EBP because of the resident's catheter.</p>