STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285209	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakefield Health Care Center	306 Ash Street Wakefield, NE 68784

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 42679 Licensure Reference Number 175 NAC 12-006.05(B) Based on record review and interviews; the facility failed to provide 2 (Resident 5 and 18) of 3 sampled residents/representatives with the cost of continuing to receive skilled Medicare Services, a choice of whether to appeal the facilities Medicare determination to discontinue services, or the reason for the discharge from skilled Medicare services. The facility census was 33. Findings are: A. Review of the facility policy Advanced Beneficiary Notice with a revised date of 6/10/23 revealed the purpose of the policy was to ensure compliance with the Centers for Medicare & Medicaid Services (CMS) regulations by issuing an Advanced Beneficiary Notice (ABN) to residents and/or representatives who are no longer covered by Medicare Part A. Residents/representatives would also be informed of potential financial responsibilities for services that Medicare may not cover. In addition, the following was revealed: -The ABN must be provided to the resident or their legal representative at least 48 hours in advance of any services that are likely to be denied by Medicare. -The form would include; the resident's name, identification number, a detailed description of services provided, explanation of why Medicare is likely to deny payment, estimated cost of service(s) and options for the resident/representative to choose regarding receiving the service(s) and accepting financial responsibility. -The ABN would be presented to the resident/representative in person. If this was not feasible, the ABN may be sent by mail with a return receipt requested and must be postmarked 5 business days prior to the ending of services to ensure the 48 hour notice was complied with. -The resident/representative must sign and date the ABN to acknowledge receipt and understanding of their potential financial responsibility. (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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. Review of Resident 5's Skilled Nursing Facility (SNF)-ABN revealed the resident's skilled care services was no longer covered beginning 4/27/24 and may have to pay out of pocket for the care. There was no documented evidence of the resident/representative's decision to appeal, their desired billing options and/or declination of the skilled care services. In addition, there was no resident/representative signature and date that indicated when the responsible party was informed of the notice. Review of Resident 5's Notice of Medicare Non-Coverage revealed the resident's skilled care services would end on 4/26/24 and may have to pay for the services after that date. In addition, the resident/representative had the right to appeal the decision and there was no documented evidence the resident/representative had received and signed the notice. An interview on 6/26/24 at 6:00 AM with Resident 5's representative confirmed the SNFABN and Notice of Medicare Non-Coverage forms were not provided to the representative before services ended on 4/26/24. C. Review of Resident 18's Skilled Nursing Facility (SNF)-ABN revealed the resident's skilled care services was no longer covered beginning 2/21/24 and may have to pay out of pocket for the care. There was no documented evidence of the resident/representative's decision to appeal, their desired billing options and/or declination of the skilled care services. In addition, there was no resident/representative signature and date that indicated when the responsible party was informed of the notice. Review of Resident 18's Notice of Medicare Non-Coverage revealed the resident's skilled care services would end on 2/20/24 and may have to pay for the services after that date. In addition, the resident/representative had the right to appeal the decision and there was no documented evidence the resident/representative had received and signed the notice. An interview on 6/26/24 at 10:00 AM with Resident 18's representative confirmed the SNFABN and Notice of Medicare Non-Coverage forms were not provided to the representative on or before 2/20/24. D. During an interview on 6/26/24 at 10:15 AM the Business Office staff member confirmed [gender] had not verified Resident 5 and 18's representatives received the Notice of Medicare Non-Coverage and SNFABN prior to the service end dates. In addition, there was no documented evidence Resident 5 and 18's representatives had indicated a choice to continue to receive services and/or requested an appeal on the SNFABN's and Notice of Medicare Non-Coverage forms.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.05(9) Based on record review and interview; the facility failed to protect residents 2 and 5 from potential abuse related to an allegation of staff to resident abuse. This had the potential to affect all facility residents. The facility census was 33. Findings are: A. Review of the facility policy Abuse, Neglect, Misappropriation last reviewed 1/2024 revealed the following: -the facility would consider factors that indicated possible abuse such as staff, resident, or a family reporting abuse, verbal abuse of a resident was overheard, or failure to provide needs such as feeding, bathing, dressing, turning and positioning, -when suspicion of abuse, neglect or exploitation occurred, an investigation would be warranted, -the Administrator would investigate the incident and would include interviewing the resident's roommate if the resident, involved staff, and injuries found during a resident assessment, -while the investigation is conducted, accused individuals not employed by the facility would be denied unsupervised access to the resident, -the alleged perpetrator would be removed, and the resident protected -employees accused of alleged abuse would be immediately removed from the facility and would remain removed pending the results of the investigation, and -when abuse, neglect, or exploitation was suspected, the Nurse would: respond to the needs of the resident and protect them from further incident, notify the Director of Nursing (DON) and Administrator, obtain witness statements, suspend the accused employee pending completion of the investigation and remove the employee from resident care areas immediately. B. Review of Resident 2's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) dated 5/2/24 revealed the following: -the resident had moderate cognitive impairment but was able to recall staff names and faces, -was dependent on staff for eating, toileting, dressing, transfers, and personal hygiene, and -had diagnoses of arthritis, Alzheimer's Disease, and high blood pressure. Review of Resident 2's Care Plan last revised 6/25/24 revealed the following: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the resident received Hospice services, -the resident required extensive/dependent assist from staff for dressing, transfers, bed mobility, and personal hygiene and used the sit to stand lift for transfers with 1-2 staff members, and -had severe cognitive impairment. Review of Resident 2's Progress Notes for January 2024 revealed no entry related to the staff to resident alleged incident that occurred on 1/21/24. C. Review of Resident 5's MDS dated [DATE] revealed the following: -admitted to the facility on [DATE], -the resident had severe cognitive impairment, -the resident required substantial assistance with toileting, dressing, transfers, and personal hygiene, and -had diagnoses of heart failure, diabetes, stroke, lung disease and depression. Review of Resident 5's Care Plan last revised 6/4/24 revealed the resident required extensive assist with dressing, ambulation, bed mobility, transfers, and personal hygiene. Review of Resident 5's Progress Notes an entry on 1/22/24 at 1:19 PM revealed that the Social Services Director called Adult Protective Services regarding a potential verbal abuse allegation toward the resident. D. Interview with Licensed Practical Nurse (LPN)-Q on 6/26/24 at 7:40 AM revealed after Resident 5 let staff know about the allegation, the Director of Nursing (DON) and the Administrator were called. LPN-Q stated that the DON/Administrator said the accused staff member could continue to work but was not allowed to enter the room of the residents who made the accusations. Further interview revealed the alleged staff was allowed to continue to provide cares for other residents alone the rest of that shift but was not allowed to return to the facility after that shift. Interview with the Administrator on 6/26/24 at 2:52 PM confirmed the alleged staff was allowed to continue to finish that shift and was not allowed back to the facility. Further interview confirmed that all residents of the facility were not protected.

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F 0606 Level of Harm - Potential for minimal harm Residents Affected - Many	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 42679 Licensure Reference Number 175 NAC 12-006.04(A)(iii)(2) Based on record review and interview; the facility failed to complete the required state Nurse Aide registry checks for 2 of 5 sampled employees to prevent potential abuse/neglect of residents. This had the potential to affect all residents. The facility census was 33. Findings are: A. Review of the facility policy Abuse, Neglect, Misappropriation and Exploitation with a review date of 1/2024 revealed each resident has the right to be free from abuse, neglect, misappropriation of resident property and exploitation. Residents must not be subject to abuse by anyone, including, but not limited to facility staff, other residents, consultants, contractors, volunteers, or staff of other agencies serving the resident, family members, legal guardians, friends, or other individuals. Further review revealed the facility must not employ or otherwise engage individuals who: -have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; -have had a finding entered in the state Nurse Aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; and -Background, reference, and credentials' checks should be conducted on employees prior to or at the time of employment, by facility administration, in accordance with applicable state and federal regulations. A review on 6/25/24 of 5 employee files hired within the past 4 months revealed the following: -Housekeeper-M was hired on 3/18/24 and there was no evidence the state Nurse Aide registry was checked for potential abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; and -Transportation Aide-L was hired on 5/15/24 and there was no evidence the state Nurse Aide registry was checked for potential abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property. Interview with the business office staff member on 6/25/24 at 2:05 PM confirmed the state Nurse Aide registry was not checked for negative findings prior to Housekeeper-M's start date on 3/18/24 and [gender] had worked in the facility since being hired. In addition, the business office staff member confirmed the state Nurse Aide registry was not checked for negative findings prior to Transportation Aide-L's start date on 5/15/24 and [gender] had worked in the facility since being hired.

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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** 45739 Based on record review and interview; the facility failed to complete and submit an investigation of a fall with injury for Resident 25 and to submit an investigation of an elopement for Resident 1 within the required time frames. The sample size was 5 and the facility census was 33. Findings are: A. Review of the facility policy Abuse, Neglect, Misappropriation, last reviewed 1/2024 revealed the following: -the facility would consider factors indicating possible abuse such as staff, resident, or a family reporting abuse, if verbal abuse was overheard, or failure to provide needs such as feeding, bathing, dressing, turning, and repositioning, -once the resident is cared for and initial reporting has occurred, an investigation would be conducted, -the Administrator would investigate the incident and would include interviews from the resident's roommate, involved staff, and any injuries found during a resident assessment, -while the investigation is conducted, accused individuals not employed by the facility would be denied unsupervised access to the resident, -the alleged perpetrator would be removed, and the resident protected, -employees accused of alleged abuse would be immediately removed from the facility and would remain removed pending the results of the investigation, -when abuse, neglect, or exploitation was suspected, the nurse would: respond to the needs of the resident and protect them from further incident, notify the Director of Nursing (DON) and Administrator, obtain witness statements, suspend the employee pending completion of the investigations and remove the employee from resident care areas immediately, and -report the results of all investigations to the State Agency within five working days. B. Review of Resident 1's Minimum Data Set (MDS- a federally mandated assessment tool used in care planning) dated 5/22/24 revealed the following: -admitted [DATE], -diagnoses of Parkinson's Disease, dementia, anxiety, attention and concentration deficit, -severe cognitive impairment, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-the resident required substantial assist with toileting, dressing, personal hygiene, transfers, and bed mobility, and -the resident was using a bed alarm, a chair alarm, and an elopement alarm. Review of Resident 1's Care Plan last revised 5/28/24 revealed the following: -Resident 1 was at risk for behavior problems such as wandering or eloping related to dementia and staff were to offer tasks which diverted attention such as puzzles, -Resident 1 required limited assistance with bed mobility, dressing, personal hygiene, toileting, and transfers, -staff were to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, and books, -if the resident was exit seeking, staff were to distract to get the resident to turn around, and -staff were to monitor the wander guard device placement and battery and replace every 90 days and as needed. Review of the facility investigation form the incident involving Resident 1 revealed the event occurred on 8/27/24 (labor day was 9/4/24) and the report was faxed on 9/5/24 to the State Agency. Interview with the DON on 6/25/24 at 3:00 PM confirmed the report was not sent into the State Agency within the required 5 working day's time frame. 29638 C. Review of Resident 25's Minimum Data Set (MDS, a comprehensive assessment of each resident's functional abilities used to develop a resident's Care Plan) dated 3/13/24 revealed the resident was admitted [DATE] with diagnoses of Alzheimer's dementia, depression, and pneumonia. The following was assessed regarding the resident: -cognition was severely impaired, -required substantial to moderate assistance with dressing, personal hygiene, and toileting hygiene, -occasionally incontinent of urine, and -1 fall without injury and 2 falls with injury (except major) since the previous assessment. Review of Resident 25's Nursing Progress Note dated 12/28/23 at 9:25 PM revealed the staff heard a noise, went to check, and found the resident on the floor. The back of the resident's head had struck the dresser and the resident had profuse bleeding to the back of the head. The resident was sent to the emergency room for evaluation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Adult Protective Service's (APS) report dated 12/28/23 at 10:58 PM revealed the resident had been walking around in the resident's room without the resident's walker. The resident had fallen backwards and sustained a laceration which required medical attention to the back of the resident's head. Review of facility investigations from 6/30/23 to 12/31/23 revealed no evidence a written investigation was completed regarding Resident 25's fall with injury. In addition, there was no evidence a written investigation was submitted to the State Agency regarding this incident. An interview with the Director of Nursing (DON) and the Administrator on 6/26/24 at 9:43 AM confirmed Resident 25 had a fall on 12/28/23 at 9:25 PM. The resident fell over backwards and struck head on a dresser. The Charge Nurse was unable to determine the extent of the resident's injury due to the excessive amount of bleeding. The resident was sent to the emergency room , but all tests were negative, and no further treatment was provided/required. The staff confirmed APS was notified but the facility failed to complete and to submit a written investigation. The Administrator confirmed the facility should have completed/submitted an investigation to the State Agency.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 29638 Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview; the facility failed to ensure residents were free from unnecessary medications related to long term use of an antibiotic for 1 (Resident 18) of 5 sampled residents as there was no specified duration or supporting documentation for clinical use based on laboratory results. The facility census was 33. Findings are: A. Review of the facility policy Antibiotic Stewardship with a reviewed date of 6/2024 revealed the purpose of the program was to monitor the use of antibiotics for the facility residents. The goal of the Antibiotic Stewardship Program (ASP) was to promote the appropriate use of antibiotics, to maximize treatment outcomes and minimize unintended consequences of antibiotic therapy. If an antibiotic was indicated Prescribers were to provide complete orders including the following: -drug name, -dose, -frequency of administration, -duration of treatment (start and stop dates or number of days of therapy), -route of administration, and -indications of use. B. Review of Resident 18's Minimum Data Set (MDS- federally mandated assessment used in the development of resident care plans) dated 6/12/24 revealed diagnoses of anxiety, depression, diabetes, anxiety, depression, manic depression, and Schizophrenia. The resident received an antianxiety, an antidepressant, an anticoagulant, an antibiotic, a diuretic, and an opioid medication 7 out of 7 days of the assessment period. Review of Resident 18's electronic medical record revealed an order dated 3/8/24 for Bactrim Double Strength 800-160 milligrams (mg) to be taken daily for chronic urinary tract infections. Review of the resident's current Medication Administration Record (MAR) for 6/2024 revealed the resident continued to receive the Bactrim daily for chronic urinary tract infections. Review of Resident 18's current Care Plan with a revision date of 6/20/24 revealed no diagnosis of an active/chronic infection, or indication for use of a long-term antibiotic. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/24 at 9:33 AM the Director of Nursing (DON) confirmed Resident 18 was on a prophylactic (preventative) antibiotic, but the resident continued to have ongoing symptoms of urinary tract infections. Additional interview confirmed the order was obtained by Hospice for palliative care, and there was no specified stop date or duration for continued use of the antibiotic.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview; the facility failed to: 1) ensure an order for as needed (PRN) antipsychotic (medication used to manage psychosis, a severe mental disorder in which thoughts and emotions are impaired) medication for Resident 12 was limited to 14 days in duration; 2) implement a gradual dose reduction (GDR) when ordered for Resident 18; and 3) ensure a psychotropic (medication taken to exert an effect on the brain and/or nervous system) medication had a designated duration and a clinical rational for continued use for Resident 25. The sample size was 5 and the facility census was 33. Findings are: A. Review of the facility policy Antipsychotic Medication Use with a revised date of 12/2016 revealed psychotropic medications were to be considered only after medical, physical, functional, psychological, emotional, psychiatric, social, and environmental causes of behavioral symptoms had been identified and addressed. In addition, the medication was to be prescribed at the lowest possible dose for the shortest period and were to be subject to GDR's and re-review. The following was revealed regarding implementation of the policy: -residents were only to receive antipsychotic medications when necessary to treat specific conditions, -the Primary Care Provider (PCP) and other staff were to gather information and document to clarify behaviors, mood, function, medical condition, specific symptoms and risks to the resident and others, -the PCP was to identify, evaluate and document with input from other disciplines and consultants as needed, the symptoms that could warrant use of antipsychotic medications, -residents were not to receive PRN doses of psychotropic medications unless the medication was necessary to treat a specific condition that was documented in the clinical record, -the need to continue PRN orders for psychotropic medications beyond 14 days required the PCP to document the rationale for the extended order, -PRN orders for antipsychotic medications were not to be renewed beyond 14 days unless the PCP had evaluated the resident for the appropriateness of the medication, and -the staff were to observe, document and report to the PCP information regarding the effectiveness of any interventions including antipsychotic medications. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Review of Resident 18's Minimum Data Set (MDS- a federally mandated assessment used in the development of the resident Care Plan) dated 6/12/24 revealed the following: -diagnoses of anxiety disorder, depression, manic depression, Schizophrenia, and diabetes, -no behaviors, and -received antianxiety medication, antidepressant medication, antipsychotic medication, and hypoglycemic medication 7 of the previous 7 days. Review of Resident 18's Medication Administration Record (MAR) for 12/2023 revealed an order for Clonazepam (medication used to treat anxiety, prevent seizures, and promotes relaxation) 1.5 tablets (0.75) milligrams (mg) daily for anxiety disorder. Review of Resident 18's Recommendation History Report with the Consultant Pharmacist's (CP) monthly regimen reviews (MRR) dated 1/18/24 revealed on 12/21/23 the resident was seen by a Nurse Practitioner (NP) who recommended decreasing the dosage of the medication Clonazepam due to a potential tolerance. The resident's PCP signed off on this recommendation on 1/2/24. However, the CP was unable to determine if the new order had been implemented. Review of Resident 18's electronic medical record from 12/21/23 to 1/31/24 revealed no evidence the facility had implemented the PCP's new order to decrease Resident 18's Clonazepam. Review of the resident's MAR dated 2/2024 revealed an order dated 2/16/24 for Clonazepam 1 tablet daily. Interview with the Director of Nursing (DON) dated 6/26/24 at 9:33 AM, confirmed Resident 18's NP had made a recommendation 12/21/23 to reduce the dosage of the resident's Clonazepam. The PCP signed off on the recommendation 1/2/24 with a new order to reduce the Clonazepam from 1.5 tablets to 1 tablet daily. However, the new order was not implemented until 2/16/24 (57 days after the NP made the initial recommendation for a dose reduction). C. Review of Resident 25's MDS dated [DATE] revealed the following: -cognition was severely impaired, -diagnoses of Alzheimer's disease, pneumonia, and depression, -no behaviors, and. -received antianxiety medication, antidepressant medication, hypoglycemic and opioid medications 7 of the previous 7 days. Review of Resident 25's MMR dated 10/18/23 revealed the resident had an order for Lorazepam (medication used to treat anxiety) 0.5 mg every 8 hours as needed for anxiety and shortness of breath. The CP made a recommendation to have the resident's PCP re-evaluate the PRN medication to determine a duration date and clinical rationale for continued use. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an MMR dated 11/13/23 revealed the PCP documented a new order to continue use of the PRN Lorazepam for 3 months, however no rationale was provided regarding the continued use of the Lorazepam. A recommendation was made to contact the PCP regarding need for the clinical rationale. Review of an MMR dated 12/18/23 revealed the resident continued to receive the PRN Lorazepam 0.5 mg. Further review revealed no clinical rationale had been provided regarding the continued use of the as needed medication. Review of an MMR dated 1/16/24 revealed the resident continued to receive the PRN Lorazepam with no clinical rationale for continued use. During an interview on 6/27/24 at 2:01 PM, the DON confirmed there was no clinical rationale for the continued use of the PRN Lorazepam despite the CP recommendation's until 2/6/24 (3 months and 3 weeks later). 45739 D. Review of Resident 12's MDS dated [DATE] revealed the following: -diagnoses of dementia, diabetes, arthritis, anxiety, and depression, -severe cognitive impairment, -behaviors towards other people and not towards other people, -the resident was dependent with toileting, dressing, personal hygiene, bed mobility, and transfers, and -the resident received antipsychotic, antianxiety, and antidepressant medications. Review of Resident 12's Care Plan last revised 6/24/24 revealed the following: -staff were to administer psychotropic medications as ordered by the Physician and monitor side effects and effectiveness, -consult with pharmacy and the Physician to consider dose reductions when clinically appropriate, -discuss the need for ongoing need for use of medications with the physician. Review of Resident 12's Medication Administration Record revealed the resident had an order for Haloperidol (antipsychotic medication) give 0.25 milligrams (mg) by mouth every 4 hours as needed for delirium started 4/23/24 with no stop date. The resident received the medication 4/30/24, 5/21/24, 5/26/24, and 5/29/24. E. Interview with the DON on 6/26/24 at 7:50 AM confirmed the resident received the Haloperidol past 14 days without seeing a physician and that the order had no stop date indicated.

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	285209	A. Building B. Wing	06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wakefield Health Care Center	306 Ash Street Wakefield, NE 68784

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 42679 Licensure Reference Number 175 NAC 12-006.10D Based on observations, record review and interviews; the facility failed to ensure a medication error rate of less than 5%. Observations of 28 medications administered revealed 2 errors resulting in a medication error rate of 7.14%. The errors affected 2 (Residents 4 and 23) of 4 sampled residents. The facility census was 33. Findings are: A. Review of the facility policy Administering Medications with a review date of 4/2024 revealed the following: -Medications must be administered in accordance with the orders, including any required time frames. -Medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders). -The individual administering the medication must check the label 3 times to verify the right resident, right medication, right dosage, right time, and right route before giving the medication. B. Review of Resident 4's Medication Administration Record (MAR) dated 6/1/24 to 6/30/24 revealed a physician's order for omeprazole (medication used to reduce gastric acid in the stomach) 40 milligrams (mg) one capsule by mouth daily (take 60 minutes before meals) and was scheduled to be given at 7:30 AM. Observation of Registered Nurse (RN)-B administering medications to Resident 4 on 6/24/24 at 09:25 AM revealed, RN-B administered Resident 4's omeprazole 40 mg at this time (1 hour and 55 minutes after the prescribed time of 7:30 AM). In addition, the medication label indicated it was to be given 60 minutes before meals. An interview with RN-B on 6/24/24 at 9:25 AM confirmed Resident 4 had already been out to breakfast this A. M. and the omeprazole should have been administered 60 minutes before meals according to the physician's order. C. Review of Resident 23's MAR dated 6/1/24 to 6/30/24 revealed a physician's order for Novolog Injection FlexPen (Insulin medication injected into a person to maintain blood sugar levels within normal range) 7 Units Subcutaneously (applied under the skin) three times a day with meals. D. Review of the undated manufacturer's instructions for administration of the Novolog FlexPen insulin revealed the following procedure should be completed: -To avoid air being injected and ensure the proper dose is administered, turn the dose selector to select 2 units. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Hold the Novolog FlexPen with the needle pointing up. Tap the cartridge gently with finger a few times to make any air bubbles collect at the top. -Keep the needle pointing upwards, press the push-button all the way in until the dose selector returns to zero. A drop of insulin should appear at the needle tip. If not, change the needle and repeat. Ensure the dose selector is set at zero after air is expelled. -Turn the dose selector to the number of units you need to inject and insert the needle into the skin. -Inject the dose by pressing the push button all the way in until the dose selector returns to zero. E. Observation of RN-B on 6/24/24 at 12:15 PM preparing to administer Resident 23' Insulin (Novolog FlexPen 7 units Subcutaneously) revealed the following: -RN-B placed a needle onto the Novolog FlexPen cartridge and held it sideways, then turned the dose selector to 7 units. -RN-B injected the Insulin into the resident's skin until the dose selector returned to zero. -RN-B did not prepare the Novolog FlexPen by first expelling 2 units of potential air bubbles following the manufacturer's instructions. This had the potential to affect the resident's blood sugar levels by an inaccurate dose of insulin being administered. An interview with RN-B on 6/24/24 at 12:15 PM confirmed RN-B did not prepare Resident 23's Novolog FlexPen insulin injection by first expelling 2 units of potential air bubbles prior to selecting the ordered 7 units of insulin and should have done this to prevent a medication error.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42679 Licensure Reference Number 175 NAC 12-006.12(D)(vi) Based on observations, record review and interview the facility failed to ensure an insulin medication was labeled correctly for 1 (Resident 23) of 4 sampled residents. The facility census was 33. Findings are: A. Review of the facility policy Storage of Medications with a review date of 4/2024 revealed drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. B. Review of the facility policy Administering Medications with a review date of 4/2024 revealed the individual administering the medication must check the label 3 times to verify the right resident, right medication, right dosage, right time, and right route of administration before giving the medication. C. Review on 6/24/24 of Resident 23' Medication Administration Record (MAR) dated 6/1/24 to 6/30/24 revealed a physician's order with a start date of 4/18/24 (over 2 months ago) for Novolog Injection FlexPen (Insulin used to maintain a person's blood sugar levels within normal range) of 7 Units subcutaneously (under the skin) was to be given three times a day with meals. An observation of Registered Nurse (RN)-B on 6/26/24 at 12:15 PM administering Resident 23's insulin medication revealed the following: -The label on the Novolog FlexPen insulin indicated the dosage was 11 units Subcutaneously TID (Three times a day) 15 minutes before a meal. -RN-B gave the resident 7 Units of Novolog insulin. RN-B confirmed the ordered 7 Units of Novolog insulin on the MAR was correct and the label on the medication was not correct and should have had a pink sticker on it to alert staff there was a change in the medication instruction. -An observation of the label revealed no evidence a pink sticker was on the label An interview with RN-B on 6/26/24 at 12:15 PM confirmed there was no sticker on the label to alert staff of a change in the medication instruction related to Resident 23's Novolog FlexPen insulin and the dosage had changed over 2 months ago.

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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 (B) Licensure Reference Number 175 NAC 12-006.18(D) Based on observations, record review and interview; the facility failed to implement enhanced barrier precautions (EBP-an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO's) when providing assistance with high-contact care activities for Resident 4, to wash hands and change gloves at indicated intervals during the provision of cares for Resident 12, to transport soiled linens and to clean re-useable care equipment to prevent the potential for cross contamination. The total sample was size 17 and the facility census was 33. Findings are: A. Review of the facility policy Enhanced Barrier Precautions that employs gown and glove use during high contact resident care activities) with a review date of 5/2/24 revealed it was the policy of the facility to implement EBP's for the prevention of transmission of MDRO's. The following was identified regarding the initiation of EBP's: -the facility will have the discretion in using EBP for residents who do not have a chronic wound or an indwelling medical device or MDRO colonization. -EBP will be initiated for residents with any of the following; wounds (chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, chronic venous stasis ulcers or wounds not showing any healing or progression towards healing after 6 weeks of treatment and/or medical devices such as central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. B. Review of Resident 13's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 2/13/24 revealed the resident was admitted [DATE] with diagnoses of anemia, high blood pressure, dementia, arthritis, and malnutrition. The resident was assessed as having severe cognitive impairment intact, required set-up assistance with personal hygiene and dressing, was independent with toileting hygiene and was continent of bowel and bladder. The resident was at risk but did not have any pressure ulcers at the time of this assessment. Review of Skin and Wound Observation Tools for Resident 13 revealed the following: -3/7/24 at 2:46 PM the resident had a reddened area to the resident's coccyx/lower spine. -3/14/24 at 10:29 AM the resident's coccyx remained red. -3/21/24 at 10:20 AM the resident had a pressure ulcer to the resident's right buttock which measured 0.7 centimeters (cm) by 0.7 cm and a pressure ulcer to the resident's left buttock which measured 0.5 cm x 0.5 cm. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/16/24 at 12:59 PM the pressure ulcer to the resident's right buttocks measured 0.3 cm. 5/30/24 the pressure ulcer to the resident's left buttock measured 0.5 cm by 0.5 cm with a depth of 0.1 cm and the pressure ulcer to the resident's left buttock measured 0.3 cm by 0.3 cm. 6/6/24 at 11:15 AM the resident's pressure ulcer to the left buttock measured 0.5 cm by 0.4 cm by 0.1 cm. 6/13/24 at 9:55 AM the pressure ulcer to the resident's left buttock measured 0.5 cm by 0.5 cm During an observation of Resident 13's room on 6/24/24 from 9:46 AM to 3:15 PM, and on 6/25/24 from 7:00 AM to 11:55 AM, there was no signage on or around the resident's room to indicate the resident was on EBP. In addition, there was no additional PPE available and/or stored in the resident's room. During an observation of cares on 6/25/24 at 11:55 AM, Nursing Assistant (NA)- F provided the resident with toileting, incontinence cares and transfer assistance. NA-F wore disposable gloves throughout the observation but did not utilize any additional PPE. An interview with NA-F on 6/25/24 at 12:22 PM confirmed despite the resident's ongoing and unresolved pressure ulcers the resident had not been placed on EBP. Interview with the Director of Nursing (DON) and the Administrator on 06/27/24 at 10:48 AM confirmed the resident had received treatment and monitoring of pressure ulcers to the resident's buttocks for several weeks. In addition, the resident should have been placed on EBP based on the non-healing pressure ulcers. 45739 C. Review of the facility policy Standard Precautions, last reviewed 6/2024 revealed the following: -hand hygiene referred to handwashing with soap OR using alcohol-based hand rub, -hands would be washed with soap and water whenever visibly soiled or after direct or indirect contact with dirt, blood, or body fluids, -in the absence of visibly soiled hands, alcohol-based hand rubs were preferred, -staff were to wash hands after removing gloves, -staff were to change gloves as necessary during the care of a resident to prevent cross-contamination from one body site to another (moving from dirty to clean), -staff were to remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-staff were to handle, transport, and process used linen soiled with blood, bodily fluids, secretions, excretions in a timely manner that prevented contamination of clothing, and avoided transferring microorganisms and environments, and -reusable equipment would not be used for another resident until it had been appropriately cleaned. D. An observation on 6/26/24 at 7:15 AM Medication Assistant (MA)-O donned gloves and obtained the soiled washcloth and towel used to perform peri cares from the bathroom and walked to the resident's bed and placed the soiled items on a soaker pad on the bed. MA-O stated that the soaker pad was wet and needed changed. MA-O then balled up the soaker pad and left the resident's room without putting the soiled linen in a bag and carried it towards the soiled utility room. E. An observation on 6/26/24 at 7:45 AM NA-H and MA-P were both wearing gloves and were assisting Resident 12, who was in bed, with dressing. MA-P went to the bathroom and obtained supplies to change the resident's brief. MA-P applied a cleanser to a washcloth then performed peri cares on the front of the resident. NA-H assisted the resident to roll onto their left side and MA-P performed peri cares on the back side of the resident. MA-P rolled the soiled washcloth up in a towel and placed the items on the floor without a barrier. MA-P, while continuing to wear the same pair of gloves, grabbed the clean brief and placed it under the resident. MA-P then obtained a barrier cream off the dresser while still wearing the dirty gloves, applied the cream and placed it back onto the dresser, then doffed and performed hand hygiene. The resident was transferred to the wheelchair using a Hoyer lift (full body lift), then MA-P donned a new pair of gloves, picked up the soiled linen from the floor and placed it on the soaker pad on the resident's bed. NA-H removed the soaker pad from the bed and stated, This is wet, I need to get a new one, balled the soaker pad up and left the resident room without putting the soaker pad in a bag to transport. NA-H returned to the resident room and removed the resident to the dining room. MA-P also left the resident room, and the Hoyer lift was left in the resident room. At 8:10 AM MA-P removed the Hoyer lift from the resident room without cleaning and entered another resident's room and shut the door. F. Interview on 6/26/24 at 1:45 PM with NA-H and MA-P confirmed hand hygiene was not completed at appropriate intervals and gloves were not changed when going from dirty to clean areas. Further interview confirmed that the lift was not cleaned after it was used on Resident 12. G. 6/26/24 at 2:52 PM Interview with the DON and the Administrator confirmed soiled linen should be bagged when transporting from the resident room to the soiled utility room or receptacle, full body lifts should be wiped down in between resident use and hand hygiene and changing of gloves should be performed after completing peri cares and applying a clean brief to residents. The Administrator indicated Resident 12, 18, and 28 all used the Hoyer lift.