STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285210	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crowell Memorial Home	245 South 22nd Street Blair, NE 68008

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-006.18 Based on observation, and interview, the facility failed to maintain the cleanliness and condition of walls, floors, fixtures, ceilings, and baseboards in 24 (rooms: 102, 105, 106, 113, 116, 122, 123, 125, 131, 132, 134, 144, 146, 158, 159, 162, 203, 205, 212, 215, 225, 233, 236, and 238) of 59 occupied resident rooms and the 2nd floor north hallway nurses station of the facility. The facility census was 60. Findings are: Observation on 04/15/24 between 8:05 AM and 09:30 AM, during the environment tour with the facility Maintenance Director [MD] and the Administrator, revealed the following concerns with the facility environment: - There were several scrapes on the walls by beds in resident rooms 106, 113, 223 and 236. - There were several scrapes on the wall under the window in room [ROOM NUMBER]. - There were several scrapes on the wall behind the recliner in room [ROOM NUMBER]. - There were several scrapes on the walls in the bathroom by the toilet in room [ROOM NUMBER]. - There were several scrapes on the wall in the bathroom by the toilet paper holder in room [ROOM NUMBER]. - There were several scrapes on the wall beside the bathroom door in room [ROOM NUMBER]. - There were several scrapes on the wall beside the window ledge in room [ROOM NUMBER]. - There was a large crack in the wall that extended from floor to ceiling by the bed in room [ROOM NUMBER]. - The top of the toilet tank was broken and cracked in rooms 102, 131 and 158. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The caulking was cracked and broken at the juncture of the wall to the sink in resident bathrooms in rooms 131, 132, 134, 146, 212, 225 and 238. - There were water stains and plaster peeling away on the bathroom ceilings in rooms [ROOM NUMBERS]. - There were brown stains and dirt buildup surrounding the base of the toilets in resident bathrooms in rooms 113, 122, 123, 125, 131, 134, 225 and 233. - There was a large pink colored stain on the floor under the floating toilet in resident bathroom in room [ROOM NUMBER]. - There was a large yellow stain on the floor at the entrance to the bathroom in room [ROOM NUMBER]. - The linoleum was cracked on the floor in front of the sink in the bathroom in room [ROOM NUMBER]. - The light bulbs were burned out in the bathrooms in rooms 125, 134 and 162. - The cable TV outlet cover was cracked and broken in room [ROOM NUMBER]. - The baseboard was loose and pulled away from the wall in room [ROOM NUMBER] by the door to the room and in the bathroom beside the door in room [ROOM NUMBER]. - There was a heavy buildup of dirt, wax and dust particles along the edges of the bathroom walls and corners in rooms 122, 125, 131, 203, 205, 212 and 233. - There were several dead bugs present inside the light fixtures in rooms [ROOM NUMBERS]. - There were several scrapes along the bottom of the wall underneath the window of the 2 North nurses station. Interview on 04/15/24 at 09:30 AM with the MD confirmed that those areas that had been identified during the environmental tour needed to be cleaned and/or repaired. The MD confirmed that there were no work orders for the areas identified and that the concerns had not been identified prior to the environmental tour of the facility.

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F 0607 Level of Harm - Potential for minimal harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 49164 Licensure Reference Number 175 NAC 12-006.04A3b Based on record review and interview the facility failed to conduct adult and child protective service (APS and CPS) registry checks upon hire for 1 (Nursing Assistant, NA G) of 5 sampled new employee files. Record Review of NA G's employee file revealed NA G was hired on 03-04-2024. Further review of NA G's employee file revealed results from registry checks with APS and CPS were not observed in the file. An interview conducted with the Administrator (Admin) on 4-16-2024 at 2:20 PM revealing APS and CPS registry checks are completed on hire and employees should not be allowed to work until the results are back. An interview conducted on 4-16-2024 at 2:40 PM with the Administrative Assistant confirmed APS and CPS registry checks were not completed for NA G. Record Review of the facility policy Background Investigations dated June 2015 revealed a policy statement of personal reference checks, driving record investigations, background investigations are conducted on all personnel employed with this facility. Listed under policy interpretation and implementation under #1 indicated in keeping with the Omnibus Budget Reconciliation Act of 1987 the Administrative Assistant will conduct any applicable background investigation(s) on each individual newly employed with this facility and on any current employee if such background investigation(s) is/are appropriate in light of the position for which the individual has applied. Listed under #4 when conducting background investigations, the facility may consult an or all of the following agencies, depending upon the position for which the employee was hired: -Local, state and/or federal law enforcement agencies; -Adult and Child abuse registries; -Professional licensing boards; -Nebraska state registry for nursing aides; -Consumer reporting agencies; and -other agencies as deemed appropriate in determining employment eligibility.

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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. 49164 Licensure Reference Number 175 NAC 12-006.10D Based on observation, record review and interview the facility failed to maintain a medication error rate of less than 5% which affected 1(Resident 44) of 3 sampled residents. There were 26 opportunities and 2 errors observed resulting in a 7.69% medication error rate. Facility Census was 60. Findings are: Record Review of Resident 44's active orders listing printed on 04-16-2024 revealed an order for aspirin 81 milligram (mg) delayed release tablet, take one tablet by mouth daily. Do not crush. The listing also revealed an order for DOK (generic name Docusate Sodium, a stool softener) 100 mg tablet take by mouth twice daily. An observation on 04-16-2024 at 7:30 AM of Medication Assistant (MA) D preparing medications for Resident 44, revealed MA-D took the Aspirin 81 mg medication card out and popped the pill into a clear medication cup. MA D also took the DOK 100 mg card out and popped the pill into the same clear medication cup. MA D poured the medications into a clear pouch and then placed the pouch in the pill crusher and crushed the medication. MA D removed the pouch, poured the crushed medications into a clear medication cup and mixed the medications with pudding. MA D then took the cup to Resident 44 and administered the medications. Record review on 04-16-2024 at 7:35 AM of the label on the Medication Card for Aspirin revealed: Aspirin 81 mg delayed release 1 tablet by mouth daily. Take with food and do not crush. Record review on 04-16-2024 at 7:37 AM of the label on the Medication Card for DOK revealed: DOK 100 mg tablet take by mouth twice daily. Do not crush. An interview with MA D on 04-16-2024 at 7:40 AM confirmed that the Aspirin 81 MG tablet and the DOK 100 mg tablet were both crushed. An interview with the Assistant Director of Nursing (ADON) on 04-16-2024 at 10:27 AM confirmed crushing a medication with do not crush instructions was a medication error. Record review of the facility policy titled Medication Administration dated 04-09-2024 revealed a policy statement: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Under the section Policy Explanation and Compliance Guidelines #14 Administer medication as ordered in accordance with manufacturer specifications. -Provide appropriate amount of food and fluid. -Shake well to mix suspensions. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Crush medications as ordered. Do not crush medications with do not crush instructions.

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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 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. 17285 Licensure reference Number 175 NAC 12-006.11E Nebraska Food Code 4-601.11(C) Based on observation, interview, and record review; the facility staff failed to ensure dietary staff wore beard restraints that fully enclosed all hair on the face during 2 meal service observations, failed to ensure scoops were stored separate from the flour and sugar, failed to ensure that the surface of plates stored in a plate warmer were not exposed to potential contaminants and failed to maintain the cleanliness and condition of floors, ventilation covers and ceiling tiles, the interior of conventional ovens and convection ovens, the exterior of the stove, stove back splash, convection ovens, shelf above the stove, floors in the walk in cooler, fans in the walk in cooler, pan storage units, electric slicer, and the large commercial mixer in the facility kitchen. These practices had the potential to cause food borne illness. This had the potential to affect 60 residents that resided in the facility and ate foods prepared in the facility kitchen. The facility census was 60. Findings are: A. Record review of an undated facility Policy entitled Dietary: Infection Control revealed the following information: - c. Hair restraints are required and should cover all hair. B. Record review of an undated facility policy entitled Food safety - Dietary revealed the following information: - 1. Good sanitary food handling practices with sanitary conditions maintained in the storage, preparation and serving of foods will be carried out at all times. - 6. Hair must be restrained. C. Observation during the initial kitchen tour on 04/10/24 between 7:45 AM and 8:00 AM, with the Dietary Manager [DM] in the facility kitchen, revealed the following hair restraint, storage and sanitation concerns: - The DM wore a beard restraint but it did not cover a full mustache. The beard was positioned below the mouth and did not fully enclose all the facial hair. - Inside the reach in refrigerator, a container of sour cream and cottage cheese were not labeled or dated when they had been opened. - A exhaust fan in the walk in refrigerator was heavily coated with a gray fuzzy substance that resembled dust. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- There were several areas of burnt on food particles, grease and spatters on the backslash of the stove, side and top of a convection oven, on the interior of the conventional oven and on the interior of 2 convection ovens. D. Observations during meal services on 4/10/24 between 8:00 AM and 9:05 AM and between 12:05 PM and 1:00 PM revealed the following: - The DM served the food to the residents from the steam table. The DM wore a beard restraint but it did not cover a full mustache. The beard was positioned below the mouth and did not fully enclose all the facial hair. - Dietary Aide [DA] E passed trays to the residents. DA E had on an N 95 mask that did not fully cover all facial hair. E. Interview on 04/10/24 at 01:50 PM with the facility Registered Dietician [RD] confirmed that the Dietary Managers beard net did not fully enclose the mustache and confirmed that DA E's mask did not fully contain all facial hair. The RD confirmed that the beard restraint should fully enclose all hair on the face. F. Observation on 04/11/24 between 09:00 AM and 9:45 AM with RD and the DM revealed the following storage and sanitation concerns in the facility kitchen and the service area of the dining room: - Four containers of cereal in the service area in the main dining room were not labeled or dated when opened. - There was no covers for the hot dish storage unit in the service area in the main dining room. The loaded dishes were face up with the surface of the plates exposed to potential contaminants. - There were 2 packages of crispy onions in the dry storage area that were open but not labeled or dated. - The floors in the dry storage area had several food particles present and a buildup of wax and dirt along the edges of the walls, corners and under the storage carts. - The floors in the kitchen preparation area and the dish machine area had several food particles present and a buildup of wax, dust and dirt along the edges of the walls, corners and under the counters and machines. - A pan storage 3 shelf unit, near the 3 compartment sink, had a buildup up of a fuzzy grey substance and rust in several areas where the plastic coated surface had worn away. - In the walk in refrigerator, there was no date or label indicating when a bag of carrots had been opened. - The blade on the commercial electric slicer had several areas of nicks and breaks on the blade. - The large commercial mixer guard and back splash had dried on spatters of food present. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- The large flour and the sugar bins had scoops laying on top of the product inside the bins which could cause contamination of the product from contact with the handle of the scoop. - A 4 shelve pan storage unit in the food preparation area unit had a buildup up of a fuzzy grey substance that resembled dust and rust in several areas where the plastic coated surface had worn away. - Two ventilation exhaust fans in the walk in refrigerator were heavily coated with gray fuzzy substance that resembled dust. - There were several areas of burnt on food particles, grease and spatters on the flat griddle, stove, back splash of the stove, side and top of 2 convection ovens, interior of 2 conventional ovens and the interior of 4 convection ovens - Three ceiling ventilation covers and the surrounding ceiling panels, all located directly above the center of the kitchen food preparation areas, had a heavy build up of a fuzzy dark grey substance that resembled dust and rust was present in several areas where the plastic coated surface had worn away. G. Interview with the RD on 04/11/24 at 9:45 AM confirmed the identifed areas of concern and that the issues need to be addressed and corrected. The RD confirmed that food contamination potentially could occur due to the sanitation issues identified. H. Interview with the RD on 04/11/24 at 10:05 AM confirmed that all residents ate foods prepared in the facility kitchen.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 49164 Licensure Reference Number 175 NAC 12-006.17B Based on observation, interview, and record review the facility failed to handle linens and a catheter drainage bag in a manner to prevent the potential for cross contamination for 1(Resident 44) of 3 sampled residents. The facility census was 60. Findings are: A. Record review of Resident 44's Comprehensive Care Plan (CCP, Care that is planned and coordinated around the resident's physical, mental and cognitive health needs) with a review date of 04-02-2024 revealed Resident 44 had a diagnosis of Chronic Kidney Disease Stage 3 (CKD3, mild to moderate loss of kidney function) and had a hospitalization in March of 2024 for an Acute Kidney Injury (AKI, is the sudden loss of kidney function) and returned to the facility with an indwelling catheter (a tube inserted into the bladder to drain urine). The approaches listed on the CCP to care for the indwelling catheter are: -Be sure catheter tubing does not become kinked or placed under the legs to promote adequate drainage. -Do not allow any part of the drainage system to touch the floor. -Monitor for changes in urinary output and/or infections: such as foul odor, blood in the urine, decreased output, or sediment in the urine. -Obtain order and change catheter per physician instructions. -Follow up after hospitalization with nephrology and urology. -Labs per physician order. -Provide catheter care with 2 staff each shift. An observation on 04-16-2024 at 6:55 AM with Nursing Assistant (NA) B and NA C providing catheter care for Resident 44. NA C donned a gown and gloves and entered Resident 44's room. NA C went to the bathroom and obtained a stack of dry wipes (a disposable linen washcloth) and placed them into the sink basin and turned on the water. After wipes were moistened, NA C took the wipes out of the sink basin and placed them on top of the handrail on the right side of Resident 44's bed. After exposing the insertion site of the catheter, NA C took a wipe off the stack on the handrail and wiped around the top of the catheter insertion site. NA C threw away the wipe and obtained another wipe off of the stack on the handrail and wiped around the bottom of the insertion site, then discarded wipe into the trash. Then NA C took another wipe off the stack on the handrail and wrapped the wipe around the catheter tubing and wiped the tubing from insertion site down. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 04-16-2024 at 7:10 AM with NA C confirmed that the wipes were placed in the sink basin and the basin of the sink is considered contaminated. NA C also confirmed that the wipes were placed on the handrail and should not have been. An interview with the Assistant Director of Nursing (ADON) on 04-16-2024 at 11:20 AM confirmed that placing wipes in the sink basin or on the handrail could cause cross contamination. B. An observation on 04-16-2024 at 6:35 AM revealed Resident 44 was lying in bed and the indwelling catheter bag was hanging on the bed frame without a cover, touching the floor mat that was located on the left side of Resident 44's bed. An interview on 04-16-2024 at 6:40 AM with NA B, who had entered Resident 44's room confirmed that the indwelling catheter bag was uncovered and was touching the mat that was on the floor. An interview on 04-16-2024 at 6:45 AM with the facility Infection Preventionist (IP)-A in Resident 44's room confirmed that the indwelling catheter bag should been covered and not have contact with the mat on the floor. Record review of the undated facility policy titled Catheter Care revealed the objective of catheter care is to maintain patency, prevent infection by performing catheter care at least one time per shift, and monitoring of catheter function. Step 11 indicates to make sure catheter tubing is hanging properly below the resident's bladder level. Check the drainage bag for leaks. Observe for urine flow; report any abnormalities to the area charge nurse. Have the drainage bag off the floor. An interview conducted on 04-16-2024 at 11:21 AM with the ADON confirmed the catheter drainage touching the mat on the floor could cause cross contamination. Record Review of the facility policy Infection Prevention and Control Program dated 02-20-2020 revealed a policy statement as follows; This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Under policy explanation and compliance guidelines #11 Linens: -laundry and direct care staff shall handle, store, process and transport linens to prevent the spread of infection. -Clean linen shall be separated from soiled linen at all times. -Clean linen shall be delivered to resident care units on covered linen carts with covers down. -Linen shall be stored on all resident care units on covered carts, shelves, in bins, drawers or linen closets. -Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. -Environmental services staff shall not handle soiled linen unless it is properly bagged.