STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285231	A. Building B. Wing	05/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Haven Living Center	1400 Mark Drive Wahoo, NE 68066

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.09D3(5) Based on interview and record review; the facility failed to monitor bowel movements and provide prn medication per facility elimination protocol to prevent the potential of constipation for 1 (Resident 40) of 5 sampled residents. The facility census was 78. Findings are: A review of the facility Elimination Protocol revised 6/2014 stated each night, after midnight, the night nurse will review the elimination records for their nurses' station. From this review, they will generate a list of residents who are in need of interventions for bowel management. This list will be documented below: -1st Day (24-hour period without a BM) -Offer 4 oz prune juice or natural laxative and document in the intervention column, -2nd Day (48-hour period without a BM)-Give 30 milliliters Milk of Magnesia by mouth (or whatever as needed medication is ordered by their physician) on the 6-2 shift. Document on the MAR and intervention column. -3rd Day (72 hours without a BM)-Charge nurse to assess bowel sounds, palpate and document assessment results. The bowel assessment should be done by day charge nurse (in event there are absent bowel sounds hat indicate physician notification) and again by the evening charge nurse prior to suppository administration. You will also determine if resident is uncomfortable and document. Then give Dulcolax or glycerin suppository as ordered to be given rectally at a time that is agreeable to the resident (generally given on 2-10 PM shift, after supper unless otherwise requested by resident) Document on the MAR, 24-hour sheet (form used by nurse to relay information about residents from one shift to the next), and intervention column. -4th Day-If above interventions have not been successful, advance to enema as ordered and continue with bowel assessments each shift until resolved. The attending physician should also be contacted as appropriate. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 40's Medical Diagnosis dated 5/8/2024 revealed Resident 40 admitted to the facility on [DATE] with diagnoses of dementia (general term for loss of memory, language, problem-solving and other thinking abilities that interfere with daily life), delusional disorder (a mental health condition in which a person can't tell what's real from what's imagined), anxiety (a feeling of fear, dread, and uneasiness), depression (persistent feeling of sadness and loss of interest interfering with daily activity) and hypertension (elevated blood pressure). A record review of the Quarterly MDS (Minimum Data Set-a comprehensive assessment that measures a residents functional, medical, psychosocial, and cognitive status) dated 3/25/2024 revealed a BIMS (Brief Interview for Mental Status) score of 7 which suggests severe cognitive impairment. Further review of Section H: Bladder and Bowel indicated the resident is frequently incontinent of urine and always continent of bowel. Further review of Section GG: Functional Abilities and Goals indicated the resident requires supervision to touching assistance with ambulation with walker, partial to moderate assistance to transfer on and off the toilet, and substantial to maximal assistance for hygiene after using the toilet and clothing adjustment. A record review of the Order Summary Report printed 5/8/2024 revealed the following bowel medications that are ordered for the resident: -Dulcolax suppository (medication used to treat constipation) every 24 hours as needed -Milk of Magnesia (used for constipation) 30 milliliters daily as needed -Miralax (used for constipation) every 24 hours as needed A record review of the resident's bowel elimination records for February, March, April, and May revealed bowel movements on the following days: 2/3/2024, 2/5/2024, 2/7/2024, 2/8/2024, 2/13/2024, 2/14/2024, 2/22/2024, 2/24/2024, 2/28/2024 3/2/2024, 3/4/2024, 3/5/2024, 3/8/2024, 3/12/2024, 3/16/2024, 3/18/2024, 3/19/2024, 3/23/2024, 3/24/2024, 3/26/2024, 3/27/2024, 3/30/2024 4/2/2024, 4/3/2024, 4/4/2024, 4/5/2024, 4/6/2024, 4/7/2024, 4/8/2024, 4/9/2024, 4/13/2024, 4/15/2024, 4/18/2024, 4/19/2024, 4/21/2024, 4/22/2024, 4/24/2024, 4/29/2024 5/4/2024, 5/6/2024, 5/7/2024, 5/9/2024, 5/12/2024, 5/13/2024. A record review of the February 2024 MAR (Medication Administration Record-record used to document medications administered to a resident) revealed Miralax and a Dulcolax suppository were administered on 2/19/2024 and Milk of Magnesia was administered on 2/21/2024. There is no documentation of a medication given for bowels between 2/8/2024 and 2/13/2024 or between 2/24/2024 and 2/28/2024. A record review of the March 2024 MAR revealed Milk of Magnesia was administered on 3/20/2024. There is no documentation of a medication given for bowels between 3/8/2024 and 3/12/2024, 3/12/2024 and 3/16/2024, and 3/27/2024 and 3/30/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the April 2024 MAR revealed no bowel medications were given between 4/9/2024 and 4/13/2024, 4/15/2024 and 4/18/2024, and 4/24/2024 and 4/29/2024. A record review of the May 2024 MAR revealed no bowel medications were given between 4/29/2024 and 5/4/2024 and 5/9/2024 and 5/12/2024. A record review of Resident 40's progress notes revealed three notations related to bowels since 2/1/2024. A notation on 2/21/2024 at 5:32 AM stated the resident was on Day 6 with no documented bowel movement and resident denied abdominal pain or tenderness. Bowel sounds were active in 3 quadrants of the abdomen and less active in 1 quadrant of the abdomen. The resident was offered and attempted a Dulcolax suppository and resident refused. A notation on 4/5/2024 at 1:49 PM indicated the resident was complaining of rectal pain and was noted to have 3 external hemorrhoids and a fax was sent to the medical doctor requesting an order for Preparation H (ointment for hemorrhoid relief). A notation on 5/9/2024 at 2:05 PM indicated the medical doctor was faxed regarding Resident 40's ongoing constipation issues and requested an order for daily Miralax. An interview on 5/9/2024 at 10:15 AM with LPN-C (Licensed Practical Nurse) and MA-H (Medication Aide) revealed staff follow a bowel protocol. MA-H stated a list is given to them by the night nurse of those residents that need a natural laxative or as needed medication for their bowels. When asked if there are any residents that might be able to say they feel constipated, MA-H revealed 2 residents and that this resident might be able to. When asked if it is an issue if a resident goes 3,4, or 5 days without a bowel movement, MA-H said it depends on the issue and commented some residents might be on hospice. MA-H said agency staff do not seem to pay attention to the bowel documentation and probably forget to chart. LPN-C also stated it depends on their meal intake as well. When asked if this resident could toilet themselves, the response was maybe. LPN-C mentioned this resident has pancake call light under them so staff know when [gender] gets up and staff can then go assist [gender]. LPN-C further commented that the resident often uses a wheelchair for mobility. An interview on 5/9/2024 at 12:40 PM with Resident 40 regarding how often [gender] has a bowel movement, the resident commented oh, I go in the morning, I go in the afternoon, and I go in the evening, and laughed afterwards. A sign is observed on the bathroom door that says to use call light for help. An interview on 5/9/2024 at 10:30 AM with the DON (Director of Nursing) regarding residents' going 3, 4, 5 days without a bowel movement and no as needed medication is provided led to no response provided by the DON. An interview on 5/9/2024 at 12:00 PM with the DON revealed the facility had no specific bowel management policy but an Elimination Protocol that is followed. The DON further stated they have a PIP (Performance Improvement Project-a concentrated effort on a particular problem in one area of the facility or facility wide) in place for this issue. A copy of the PIP was requested. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the PIP titled BM (bowel movement) Elimination Protocol revealed a start date of 3/12/2024 with a goal that the elimination protocol will be followed by charge nurses and medication aides. Reasons provided by the facility for issues with bowel management include bowel movements not assessed or charted, residents eliminate independently, memory care residents forgetting whether they have or have not had a bowel movement, nurses and med aides not giving medications per the protocol. The PIP stated weekly elimination protocol forms are to be viewed and addressed with the charge nurses, one on one education with the nurses, and a skills fair checkoff to all nursing team members is the action plan to improve bowel management. An interview on 5/9/2024 at 1:50 PM with the DON led to a request of the education provided to staff or audits since 3/12/2024 to show whether there has been improvement or not. An interview on 5/9/2024 at 2:59 PM with the DON revealed a sheet of paper with 4 dates (3/12/2024, 4/15/2024, 4/24/2024, and 5/3/2024) of one-on-one education for 6 different nurses but no specific details of the education are listed. No audits provided. The DON stated there has been some improvement but there needs to be more. An interview on 5/9/2024 at 1:10 PM with NA-E revealed [gender] no training on bowel management this year but stated [gender] did do some training about how to do peri-care (cleaning of resident genitalia/rectal area). An interview on 5/9/2024 at 1:45 PM with MA-F regarding how staff knows if someone needs medication to promote a bowel movement, MA-F revealed there is a list of those residents that show what day they are on and to follow the protocol. When asked if [gender] has received any education about bowel management, MA-F replied that [gender] had not in the last couple of months but stated there was something on the dashboard in PCC (PointClickCare-software used by health care facilities to collect/store data about residents in the facility) about following policies and procedures. An interview on 5/9/2024 at 2:05 PM with MA-G regarding how staff know if a resident is constipated or needs something to help promote bowel movement, MA-G stated [gender] didn't think it was up to them to decide and would need to ask the charge nurse. If a medication was given, [gender] would document the medication as given on the MAR and bowel movements are documented in PCC.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC ,d+[DATE].11E Based on observation, interview, and record review; the facility kitchen failed to label and date a clear container of lemonade, failed to dispose of expired drink and food items in the kitchen, and failed to remove dented cans for resident use to prevent the potential of food borne illness. This had the potential to affect 78 residents. The facility census was 78. Findings are: An observation on [DATE] at 7:50 AM of the refrigerator in the kitchen revealed 3 clear beverage dispensers, one with red colored fluid dated [DATE], one with pink colored fluid dated [DATE], and one with yellow colored fluid with no label or date. A clear container of chicken salad dated [DATE] was also in the refrigerator. A bottle of Kitchen bouquet browning and season sauce is on a metal shelf in the kitchen and has an open date of [DATE] but a use-by date of [DATE]. An observation on [DATE] at 8:00 AM in the dry storage revealed a dented can of refried beans on the shelf for resident use. An observation on [DATE] at 8:20 AM of the refrigerator in the Lakemont kitchenette revealed 3 clear beverage dispensers, a pink colored fluid dated [DATE], fruit punch dated [DATE], and grape juice dated [DATE]. An observation on [DATE] at 9:31 AM during a final walk through of the kitchen revealed a dented can of applesauce and a dented can of diced peaches on the shelf in the dry storage room. An interview on [DATE] at 8:10 AM with the FSS (Food Services Supervisor) revealed the [gender] had removed all food/fluid items that were previously observed and confirmed they were expired and should have been removed for use along with the dented can of refried beans. An interview on [DATE] at 8:20AM with NA-D revealed NA-D did not know the expiration date of the drinks in the refrigerator. When notified that they should be removed after 3 days, NA-D said, I thought so, and disposed of the drinks. An interview on [DATE] at 9:32 AM with the FSS revealed the dented can of applesauce and peaches should have been removed from the shelves. An interview on [DATE] at 11:01 AM with the RD (Registered Dietician) confirmed that dented cans should be removed from use for the residents. The RD stated [gender] placed a copy of the Dented Can Guide from Sysco in the dry storage room and would in-service staff on All about Can Safety. A record review of the facility policy Food Storage dated 2010 stated under Procedure: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	13. Leftover food is stored in covered containers or wrapped carefully and securely. Each item is clearly labeled and dated before being refrigerated. Leftover food is used within 3 days or discarded. 14. Refrigerated Food Storage: f. All foods should be covered, labeled, and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable) or discarded. A record review of the undated Dented Can Guide from Sysco stated to discard cans with severe dents on side seam, sharp dents parallel to rim, sharp dents on the side that prevent stacking, buckled or pinched tops and bottoms, leaks, bulges or puffed ends, ends that give or flip and bulge on the other end when pushed, and severe dents on the rims, seam, or bent rims.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49383 Licensure Reference Number 175 NAC 12-006.17B Licensure Reference Number 175 NAC 12-006.17D Based on observation, record review, and interview; the facility failed to perform hand hygiene between the removal of soiled gloves and application of new gloves during resident care and applied an incontinence brief that was picked up off the floor and failed to perform hand hygiene prior to application of cream to prevent the spread of infection and prevent the potential of cross contamination for 2 (Resident 53 and Resident 55) of 3 sampled residents. The facility also failed to prevent the potential of cross contamination by picking up a dropped medication on the medication cart with bare fingers for 1 (Resident 18) of 4 sampled residents. The facility census was 78. Findings are: A. An observation on 5/9/2024 at 10:00 AM revealed LPN-C (Licensed Practical Nurse) had completed flushing Resident 53's indwelling foley catheter. LPN-C proceeded to wash around the resident's urinary meatus (opening where urine exits the body). LPN-C performed hand hygiene with soap and water at the sink for 20 seconds. LPN-C applied gloves and applied Nystatin cream to resident's penis/urethral area. LPN-C removed soiled gloves and applied new gloves. LPN-C then palpated the resident's abdomen, pulled the trash can closer to the bed, assisted the resident to [gender] side with assistance from NA-E (Nursing Assistant) to assess buttocks. The resident's soiled brief was removed and placed in the trash by LPN-C. LPN-C bent down to pick up an opened brief (skin side down) off the floor and applied the brief to the resident. The resident's pants were pulled up by both staff members. LPN-C lowered the bed with control. LPN-C then removed and threw away the soiled gloves. An interview on 5/9/2024 at 10:15 AM with LPN-C confirmed that [gender] should have performed hand hygiene between removal of soiled gloves and application of new gloves and a brief that was lying on the floor should not have been used on the resident. An interview on 5/9/2024 at 10:30 AM with the DON (Director of Nursing) confirmed that hand hygiene needs to be performed between glove exchange and a brief that was lying on the floor should not have been used for resident use. A record review of the facility policy Hand Hygiene revised 8/20/2023 from the [NAME] Procedural manual stated that washing with soap and water is appropriate when the hands are visibly soiled or contaminated with blood or other body fluids, when exposure to potential spore forming pathogens is strongly suspected or proven, and after using the rest room. An alcohol-based hand rub is appropriate for decontaminating the hands: -before direct patient contact, putting on gloves, or inserting an invasive devise, -when moving from a contaminated body site to a clean body site during patient care, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-after contact with a patient or with body fluids, excretions, mucous membranes, nonintact skin, or wound dressings, -after contact with inanimate objects in the patient's environment, -after removing gloves. 47406 B. Record review of Resident 55's Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) dated 3/6/24 revealed Resident 55's admission was 03/09/2022. Record review of Resident 55's Diagnosis Sheet dated 5/16/24 revealed retention of urine, unspecified and Flaccid Neuropathic Bladder, not elsewhere classified. Record review of Resident 55's MDS dated [DATE] revealed in section C, a BIMS (Brief Interview for Mental Status, a test used to get a quick snapshot of a resident's cognitive function, scored from 0-15, the higher the score, the higher the cognitive function) of 13 indicating resident is cognitively intact. Section H 9 revealed as Not rated, resident had a catheter (indwelling, condom), urinary ostomy, or no urine output for the entire 7 days. Record review of Resident 55's Physician Orders revision date 4/15/24 revealed Monthly catheter change 16 FR with 10cc balloon every evening shift every 1 month. Observation of Resident 55's catheter cares on 5/13/24 at 7:25 am with Medication Aide (MA)-A. NA-B assisted with resident's positioning. MA-B and NA-B donned a gown, a face shield and gloves outside the room. MA-A prepared supplies for cleansing. MA-A washed resident's groin and abdominal skin fold with soap and water using washcloth, then rinsed with another washcloth, and dried. The abdominal fold was red in color. NA-B called the charge nurse to bring in nystatin cream for the MA. MA-A applied nystatin cream to abdominal folds without changing gloves and performing hand hygiene. MA-A retracted the foreskin and cleansed the penis, then rinsed with a clean wet washcloth, and dried. Then washed and rinsed catheter tubing from urethra opening out several inches. A small amount of bleeding noted at edge of foreskin and MA-A said a small wound was there and had NA-B call the charge nurse to assess wound. The MA-A doffed gloves, then performed hand hygiene with soap and water times 20 seconds and applied new gloves. The old urinary drainage bag was dated 4/15/24. There was thick cloudy light-yellow urine with mucous and sediment in tubing and bag. MA-A cleaned the connection between the catheter and the drainage bag tubing with alcohol pads prior to attaching new urinary drainage bag. Placed the drainage bag tubing in the catheter securement device on leg and attached the bag to the bed frame. Interview on 5/13/24 at 7:37 am with MA-A revealed Yes, I should have changed my gloves, I figured my gloved hands were in the soapy water. I'm used to working in surgery. Record review of Indwelling urinary catheter (Foley) care and management, home care policy revised 12/11/2023. Policy revealed under Implementation: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Perform perineal care using mild soap, warm water, and a washcloth as appropriate. Gently clean the urethral meatus first and then clean the rest of the perineal area from front to back to avoid contaminating the urinary tract. For a patient with an uncircumcised penis, gently retract the foreskin to clean beneath it and return the foreskin to its normal position after cleaning to avoid constriction of the penis, which can cause edema and tissue damage. Rinse the area carefully and pat it dry with a towel. Avoid aggressively cleaning the meatal area and creating traction on the catheter because these actions can cause meatal irritation, tissue trauma, and infection. -As appropriate, replace the drainage bag system when clinically indicated (such as when clouding, a foul odor, or discoloration is present) and as recommended by the manufacturer using no-touch technique. To replace the drainage bag, clamp the catheter, clean the connection between the catheter and the drainage bag tubing with a disinfectant pad, and disconnect the tubing from the catheter. Then clean the tip of the new drainage bag tubing with a disinfectant pad, connect the tubing to the catheter, and unclamp the catheter. 49380 C. An observation on May 9th at 9:50 AM with MA-I as they prepared medication for Resident 18 the medication Mybetriq (a medication to treat overactive bladders) when pushed out of the bubble pack hit MA-I's ungloved hand, bounced off MA-I ungloved hand and landed on top of the medication cart. MA-I picked up the medication Mybetriq with an ungloved hand and placed it into the medication cup. MA-I then proceeded to hand the medication cup filled with Resident 18's medications and handed them to (gender) and Resident 18 swallowed the medicaiton. An interview on May 9th, 2024 at 10:10 AM with MA-I stated if a medication falls onto the top of the medication cart the medication is to be discarded and replaced with a new pill. MA-I confirmed she should have discarded the dropped medication and replaced it with a new pill. An interview on May 9th, 2024 with DON confirmed if a medication falls anywhere other than the medication cup prior to administration the medication should be discarded and replaced with a new pill. DON confirmed the medication should have been replaced to prevent contamination of the medication.