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	07/10/2025

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

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(i)(3) Based on observation, interview, and record review; the facility failed to provide toileting and repositioning for 1 (Resident 18) of 1 sampled resident who required staff assistance with these tasks. The facility census was 77.Findings are:Record review of Resident 18's admission Record dated 7/8/25 revealed the resident was admitted to the facility on [DATE].Record review of Resident 18's document titled Diagnosis dated 7/8/25 revealed diagnoses of personal history of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), frontotemporal neurocognitive disorder (a neurodegenerative brain disorder that occurs when nerve cells in the frontal and temporal lobes degenerate, causing the lobes to shrink), and mild neurocognitive disorder due to known physiological condition without behavioral disturbance (a condition where a person experiences a decline in cognitive abilities, such a memory or thinking skills, due to a known medical condition, but this decline doesn't significantly impact their daily life or cause noticeable behavioral changes).Record review of Resident 18's Minimum Data Set (MDS, a comprehensive assessment of each resident's functional capabilities) dated 4/7/25 revealed the following information about the resident:-Section C: a Brief Interview for Mental Status (BIMS, 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) score of 6, indicating Resident 18 had severe cognitive impairment.-Section G: the resident had no limitation in upper ROM (range of motion), no limitation in lower ROM, and used a wheelchair. The resident was dependent on staff assistance for rolling left to right in bed, transfers, and toileting hygiene. -Section H: the resident was always incontinent of urinary and bowel. -Section M: the resident was at risk for pressure ulcers (PU, an injury to skin and underlying tissue resulting from prolonged pressure on the skin), no PU present. The resident had pressure reducing devices in their bed and wheelchair.Record review of Resident 18's Braden Scale (a risk assessment tool that predicts a patient's likelihood of developing pressure ulcers - generally a score of 18 or less indicates at-risk status) score was 13 which indicated the resident was at moderate risk for developing pressure ulcers. The assessment was done on 7/6/25.Record review of Resident 18's Care Plan (a document that outlines the specific healthcare, personal care, or support a person will receive) dated 7/8/25 revealed: 1.ADL (activities of daily living) self-care performance deficit related to bipolar, diabetes mellitus, seizures, morbid obesity, and personal history of a traumatic brain injury.-Bed Mobility: 2 assists with turning side to side. -Toilet use: 2 assists, is incontinent of bladder and bowel, provide peri cares with brief changing as needed, check and change on a routine basis.-Transfer: the resident utilized a Hoyer mechanical lift.2. Potential for alteration in bowel elimination related to decreased mobility, antidepressant meds, history of diverticulitis and blood in the stool. -Bowels will be managed without complications through the review date.-monitor bowel elimination pattern PRN, monitor/document/report PRN complications related to bowel elimination.3. Potential/actual impairment to skin integrity related to diabetes, immobility and incontinence. History of a stage 2 pressure ulcer to the tailbone that was healed on 11/12/24.-offload coccyx by turning left/right at frequent intervals. -Pressure-relieving devices to chair (aqua gel cushion) and bed.-Provide peri care after each incontinent episode. Observation on 7/7/25 at 9:34 AM of Resident 18 revealed the resident was sitting in their wheelchair, tilted back, in their room with the TV on. The resident was sleeping and there was a Hoyer lift sling underneath the resident. Observation on 7/8/25 at 6:55 AM of Resident 18 revealed the resident was sitting in their wheelchair in an upright position by the nurse's station with the Hoyer sling underneath the resident. Observation on 7/8/25 at 7:20 AM of Resident 18 revealed the resident was sitting up to the dining room table in their wheelchair in an upright position waiting for breakfast with the Hoyer sling underneath resident.Observation on 7/8/25 at 8:10 AM of Resident 18 revealed the resident continued to be sitting at the dining room table in their wheelchair in the same upright position waiting for their breakfast tray with the Hoyer sling underneath resident.Observation on 7/8/25 at 8:45 AM of Resident 18 revealed the resident had finished eating and was taken back to their room. The resident was sitting in their wheelchair in a tilted back position and sitting in front of the TV. Resident 18 had a blanket covering them with the Hoyer sling underneath resident. Observed the wheelchair front wheels were turned toward the bed.Observation on 7/8/25 at 9:33 AM of Resident 18 revealed the resident was asleep in their wheelchair with Hoyer sling remaining underneath resident. The wheelchair front wheels remained turned toward the bed and the wheelchair was tilted back in the same position. Observation on 7/8/25 at 9:56 AM of Resident 18 revealed

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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. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference number 175 NAC 12-006.18 Based on observations, interviews, and record reviews; the facility failed to ensure staff performed hand hygiene between glove changes, perform hand hygiene via soap and water for 20 seconds, and did not use contaminated gloves when getting clean wipes out of the wipes container for 1 (Resident 18) of 1 sampled resident to prevent the potential for cross contamination. The facility census was 77.Findings are:Record review of Resident 18's admission Record dated 7/8/25 revealed the resident was admitted to the facility on [DATE].Record review of Resident 18's document titled Diagnosis dated 7/8/25 revealed diagnoses of personal history of traumatic brain injury (brain dysfunction caused by an outside force, usually a violent blow to the head), frontotemporal neurocognitive disorder (a neurodegenerative brain disorder that occurs when nerve cells in the frontal and temporal lobes degenerate, causing the lobes to shrink), and mild neurocognitive disorder due to known physiological condition without behavioral disturbance (a condition where a person experiences a decline in cognitive abilities, such a memory or thinking skills, due to a known medical condition, but this decline doesn't significantly impact their daily life or cause noticeable behavioral changes).Record review of Resident 18's Minimum Data Set (MDS, a comprehensive assessment of each resident's functional capabilities) dated 4/7/25 revealed the following information about the resident:-Section C: a Brief Interview for Mental Status (BIMS, 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) score of 6, indicating Resident 18 had severe cognitive impairment.-Section G: the resident had no limitation in upper ROM (range of motion), no limitation in lower ROM, and used a wheelchair. The resident was dependent on staff assistance for rolling left to right in bed, transfers, and toileting hygiene. -Section H: the resident was always incontinent of urinary and bowel. Observation on 7/8/25 at 11:48 AM revealed Nurse Aide (NA)-A and Medication Aide (MA)-B were performing peri cares and repositioning for Resident 18. MA-B was in the resident's room wearing gloves and had Resident 18 hooked up to the Hoyer lift (an assistive device that helps transfer patients between resting places like beds or chairs). NA-A applied alcohol based hand rub (ABHR) to their hands and then applied gloves. MA-B started to lift Resident 18 using the Hoyer lift and noted some loose bowel movement dripping onto the floor, lift sling, and the lift leg bar. NA-A cleansed the lift leg bar off and the floor with a cleansing wipe to remove the loose stool. NA-A removed their gloves and performed hand hygiene with soap and water for 7 seconds, dried their hands and applied new gloves. The resident was then assisted into bed. NA-A and MA-B removed the resident's sling and pants. NA-A and MA-B took cleansing wipes out of the wipes container with their contaminated gloves several times while wiping bowel movement off the resident's inner legs. NA-A and MA-B then removed the resident's incontinence brief that was saturated with urine and loose bowel movement. MA-B removed cleansing wipes from the wipes container several different times with the same contaminated gloves and finished cleansing resident's groin, peri-area, and buttocks with different wipes each time. NA-A performed hand hygiene with soap and water for 5 seconds and then applied new gloves. MA-B changed their gloves without performing hand hygiene. NA-A and MA-B then placed a clean brief and clothes on Resident 18 and assisted the resident up into their wheelchair with the Hoyer lift.An interview on 7/8/25 at 1:45 PM with MA-B confirmed the MA should have performed hand hygiene when changing gloves and should not have used contaminated gloves while getting new cleansing wipes out of the container. An interview on 7/8/25 at 1:47 PM with NA-A confirmed they should have performed hand hygiene for 20 seconds when using soap and water and should not have used contaminated gloves while getting new cleansing wipes out of the container.An interview on 7/8/25 at 1:50 PM with the Director of Nursing (DON) confirmed that MA-B should have performed hand hygiene when changing gloves, NA-A should have performed hand hygiene for 20 seconds with soap and water. The DON also confirmed that NA-A and MA-B should not have used contaminated gloves while getting new cleansing wipes out of the container. Record review of the facility's Hand Hygiene Competency policy revised 12/2019 revealed the following procedure: 1. Check for paper towels before starting hand hygiene procedure. 2. Turn on water and wet hands. Water should be warm, not hot or cold. 3. Apply soap, use friction, rub hands together. Clean around and under nails/jewelry and between fingers. Wash up on to wrist (approximately 2 inches above wrist). 4. Lather and rub hands together for full 20 seconds. 5. While positioning hands lower than wrists, rinse hands well under warm water without touching the inside of the sink or the faucet to hands. (These areas are always