STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Ridge Post Acute Nursing and Rehab	7501 Keystone Drive Omaha, NE 68134

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 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

50683

Licensure Reference Number 175 NAC 12-006.05(21)

Based on observation and interviews, the facility failed to treat 2 of 2 sampled residents (Residents #36 and #8) with dignity, respect, and care that promotes maintenance and enhancement of the resident's quality of life while recognizing the individuality of each resident. The facility identified a census of 73.

Finding are:

On 5/01/2024 during observation of meal service in the main dining room between 12:10 PM and 12:46 PM revealed Cook-F dishing food and serving in the dining room in random order and not according to where residents sat resulting in residents eating food in front of their tablemates for up to 30 minutes before other table mates being served. At 12:19 PM, Resident # 36 was sitting at a table by themselves but became visibly upset when surrounding tables of residents were served their meal between 12:10 PM and 12:20 PM. At 12:27 PM Resident #36 stood and reached for their walker to leave the dining room when their meal was served and sat back down at the table to eat lunch meal. Three residents seated together at a table in the main dining room were served at different times (12:10 PM, 12:16 PM, and 12:30 PM).

An interview on 5/1/2024 at 12:19 PM with Resident # 36 revealed that the resident was upset that tables all around were being served lunch and then stated, This is bullshit and points to the other residents were being served.

Observation at 5/01/2024 at 12:32 PM noted the Certified Dietary Manager (CDM) asking in a loud raised voice to Cook-F What is this for? The CDM was holding a plate resembling a Peanut Butter and Jelly sandwich. Cook -F replied back in a loud, raised voice It is for 'resident's first name'.

An observation on 5/2/2024 at 8:04 AM revealed Dietary Assistant (DA)-G was preparing to serve breakfast to residents in the Garden Cafe. DA-G did not refer to the individual meal tickets but instead spoke in a loud, raised voice to the residents when they entered the dining room What do you want for breakfast? The residents were over approximately 40 feet away.

An observation in the Garden Cafe dining room on 5/02/2024 at 8:10 AM revealed Resident #52 saying out loud, This is how they always talk to us, always yelling at us.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285238	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/02/2024
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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An observation on 5/02/2024 at 8:20 AM in the Garden Cafe Dining Room, revealed Resident #8 pouring coffee from their coffee cup into a Pepsi Bottle and the resident accidentally spilled the coffee on the table and the floor. The CDM was overheard speaking to Resident #8, in a loud voice, asking the resident if they were pouring their coffee and spilling it. The CDM went on to say, You can't do that! You will get burned! Other residents in the dining room stopped talking and eating to look at the resident who was being talked to. Resident #8 appeared embarrassed and tried to explain that (gender) wanted to save the coffee for later. An observation on 5/02/2024 at 8:21 AM in the Garden Cafe' Dining Room revealed Resident #52 stating loudly, See, this happens all the time, you should be here every day. On 05/02/2024 at 11:50 AM an interview with Resident #8 revealed when asked if it bothered them how the CDM talked to them that morning. The resident replied, I don't let things like that bother me. Review of CMS document Your Rights and Protections as a Nursing Home Resident referenced at https://downloads.cms.gov/medicare/Your_Resident_Rights_and_Protections_section.pdf revealed You have the right to be treated with dignity and respect.

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50683 Licensure Reference Number 175 NAC 12.006.05 (4) Based on observation, interview and facility documentation, the facility failed to allow 1 of 18 residents sampled (Resident #25) the right to make choices regarding their wishes for or against life sustaining measures. The facility identified a census of 73. Finding are: Record review of Resident #25's profile in the Electronic Medical Record (EMR) revealed the resident admitted to the facility [DATE]. Record review of Resident #25's quarterly Minimum Data Set (MDS, a federally mandated assessment tool used to determine a residents plan of care) dated [DATE] revealed in Section C, under the Brief Interview for Mental Status (BIMS) (a tool used to determine a residents mental cognition) a score of 15, which indicates the residents mental status is cognitviely intact. Section GG revealed the resident was set up for all activities of daily living. Record review of Resident # 25's code status on [DATE] at 8:40 AM revealed that the resident's code status in their Point Click Care (PCC) EMR dashboard did not match the resident's signed Do Not Resuscitate (DNR) form under miscellaneous Advanced Directives. The PCC 's dashboard indicated that Resident # 25 is a No Code and the signed DNR form dated [DATE] indicated a Full Code. A Full Code is an Advance Directive choice that means that when the resident's heart stops beating (when the person dies), that trained medical professionals will do everything medically possible to try and restart the resident's heart by providing Cardiopulmonary Resuscitation (CPR). A No Code is an Advance Directive choice that means CPR will not be attempted when the person dies. Record Review of Resident #25's medical record revealed a DNR form dated [DATE] was later located in the EMR under miscellaneous Other that indicated No Code. An interview on [DATE] at 8:45 AM with Resident #25 revealed, when asked if (gender's) heart would stop beating or they would stop breathing, would they want CPR (Cardiopulmonary Resuscitation) started, the resident replied, Absolutely YES. An interview with Social Service Staff (SS-L) at 8:49 AM on [DATE] revealed that the resident's code status is on the resident's chart and in a book at the nurse's station. The resident's code status is also listed in PCC. A blue star on the resident's name identifier outside of their room indicates that the resident is a Full Code. An interview with the Director of Nursing (DON) on [DATE] at 9:10 AM revealed that the DON verbalized that Resident #25 was confused, and that resident's relative is the Durable Power of Attorney (DPOA) and that the DPOA signed the code status form as a DNR. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Record review of Resident #25's DNR form revealed a relative who lives out of state signed the DNR form. The facility accepted the signed DNR form. An interview on [DATE] at 9:12 AM with the SS-L revealed that the facility process is to ask the resident or the representative upon admission their wishes regarding Advance Directives. The nurse will then enter their preferred code status in the computer and the Medical Director then electronically signs the code status order. The code status form is then placed in a binder, which is kept at the nurse's station. SS-L confirmed that if the resident desires to be a Full Code, then a blue star is placed on the resident name identifier located on the outside of their door. If the resident desires to be a No Code then no star is placed. An interview with the Social Service Director (SSD) at 9:15 AM on [DATE] when the asked about Resident's #25 verbalizing they wanted to be a Full Code. SSD stated the Patient goes back and forth. SSD reported that they ask every resident at their care conference about their code status. SSD reported that Resident #25 was asked about their desired code status and that Resident #25 requested that their family can sign for their code status, SSD also reported that Resident #25 gets confused about the verbiage of DNR and Full Code. Further interview with the SSD on [DATE] at 9:17 AM revealed that when the facility received a signed advance directive,they upload the document into PCC under the Miscellaneous Tab Advanced Directives. The nurse then sends an order to the Medical Director to sign and then the staff update their code status in PPC and initiate the blue star as appropriate. An interview at 11:45 AM on [DATE] with the SSD revealed that Resident #25 has a DPOA in place and the resident's relative is the resident's DPOA and can make code status decisions. An interview at 2:30 PM on [DATE] with the SSD revealed that Resident #25's DPOA was not enacted, and that Resident #25 is their own person and can make informed decisions. SSD reported that the facility had updated the code status to Full Code. Record review of a Policy/Procedure titled Advance Directive with a revision date of ,d+[DATE] revealed under Section: Care and Treatment: It is the policy of this facility that a resident's choice of advance directives will be recognized and respected.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 17285 Licensure Reference Number 175 NAC 12-006.05(15) Based on observation and interview; the facility failed to ensure full visual privacy in 3 (resident rooms 511, 513 and 529) of 49 dual occupancy rooms as evidenced by no privacy curtains present that would surround the bed to ensure visual privacy from the doorway or the resident's roommate. This had the ability to affect 3 residents, Residents 8, 38 and 63, that resided in those rooms. The facility census was 73. Findings are: Observation on 04/29/24 at between 3:00 PM and 3:15 PM in the Garden level of the facility revealed no privacy curtains were present that could surround the beds to provide visual privacy in resident rooms 511, 513 and 529. Interview on 05/02/24 between 8:00 and 9:15 AM with Maintenance Director confirmed that there were no privacy curtains present that could surround the beds that would provide visual privacy from the doorway or the residents roommate if they had to exit the room in double occupancy resident rooms 511, 513 and 529. The Maintenance Director confirmed that, without privacy curtains, the residents could be visibly seen from the hallway or the residents' roommate.

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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 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, curtains, fixtures, ceiling tiles, ventilation covers, baseboards, doors and nightlight's in 23 (Rooms 511, 512, 513, 514, 516, 520, 521, 525, 526, 528, 5101, 5104, 5106, 5109, 5110, 5116, 5118, 5119, 5121, 5123, 5124, 5126 and 5128) of 43 total occupied resident rooms, the bath house on both levels of the facility, the activity room on the garden level of the facility, the walls across from the elevator and across the nurses station on the garden level and hand rails on both levels of the facility. The facility failed to ensure that rooms were homelike as evidenced by no closet doors present in 19 (Rooms: 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 524, 525, 526, 527, 528, 529) of 19 occupied resident rooms on the garden level of the facility. The facility census was 73. Findings are: Observation on 05/02/24 between 8:00 AM and 9:15 AM with Maintenance Director [MD] revealed the following concerns with the facility environment: - The caulking surrounding the base of the toilet was cracked and broken in resident bathrooms in rooms [ROOM NUMBERS] and the garden level bathhouse. - There were scrapes present in the drywall on walls in resident rooms 511, 513, 516, 521, 526, 5101, 5104, 5106, 5109, 5116, 5118, 5119, 5123, and 5126 and along the length of the wall by the nurses' station and the elevator on the garden level of the facility. - There were stained, brown areas present around the base of the toilet in resident bathrooms in rooms 514, 5118 and 5106 and the garden level bathhouse. - The ceiling tile was cracked/missing and bubbled in resident room [ROOM NUMBER] above the window, in room [ROOM NUMBER]'s bathroom, in the garden level bathhouse and in the activity area on the garden level of the facility. - The baseboard was pulled away from the wall in the bathroom in resident rooms 512, 516, 525, and 521 (in the room near the closet), -There were patched areas of the ceiling that were not painted in resident bathrooms in rooms [ROOM NUMBER]. - There were scraped areas in the wood of bathroom and room doors in resident rooms 512, 514, 516, 520, 5285101, 5104, 5106, 5110, and 5121. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- The ventilation system covers in resident bathrooms were coated with a gray fuzzy substance that resembled dust in resident rooms 511, 525, 526, 5101, 5109, 5116, 5118, 5119, 5121, 5123, 5124, 5126 and 5128. - There were round holes in the wall behind the door from where the doorknob came into contact with the wall in resident rooms [ROOM NUMBERS]. - The nightlight in the bathroom was broken in resident room [ROOM NUMBER]. - A wall plate was not securely attached to the wall in resident bathroom in room [ROOM NUMBER]. - The toilet paper holder is missing / broken in bathrooms in resident rooms 521, 5101, 51165118, 5119, and 5126. - The towel bars were missing or broken in resident bathrooms in rooms 521,5118, 5123, and 5124. - The window curtains were broken and loose in rooms 5101, 5104 and 5106. - A plastic glove holder was broken and jagged plastic present along the broken edge in resident bathroom in room [ROOM NUMBER]. - There was a very strong urine odor in room [ROOM NUMBER]. - The floors were soiled, wet and sticky in resident rooms [ROOM NUMBERS]. - The bathroom door in room [ROOM NUMBER] would not close unless lifted up and pushed in. - A toilet support bar in resident bathroom in room [ROOM NUMBER] was loose and missing one side of the support. It was laying on the floor and the other support bar was very loose and pushed outward away from the toilet. A toilet support bar (left side) was missing on the toilet in the bathhouse on the med center level of the facility. - There were several areas that had scrapes on the wooden handrails on both levels of the facility. - There were no closet doors present in resident rooms 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 524, 525, 526, 527, 528, and 529. Interview on 05/02/24 at 9:15 AM with the MD confirmed that those areas identified needed to be cleaned / repaired. The DM 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. The DM confirmed that having no closet doors on closets was not homelike.

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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 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** 49164 Based on record review and interview the facility failed to submit an abuse investigation to the state agency in 5 working days for 2 (Resident 61 and 80) of 7 residents. The facility staff identified a census of 73. Findings are: A. Record review of Resident 80's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 10-25-2023 revealed a diagnosis of fractured hip, dementia, and high blood pressure. The MDS also revealed Resident 80 needed moderate assistance with transfers and upper body dressing and needed maximal assistance with lower body dressing. Record review of Resident 80's progress notes dated 12-22-2024 revealed Resident 80 had fallen and was sent to the hospital for an x-ray for possible injury to (gender) recently fractured hip. Record review of the facility's investigation of the fall on 12-22-2024 revealed the state agency was not listed as notified. An interview with the Administrator (ADM) on 05-01-2024 at 1:58 PM revealed the facility did not follow up and send the investigation to the state agency. 50106 B. Record review of Resident 61 Electronic Medical Record (EMR) revealed the resident had the following diagnosis: encephalopathy (an acute neurological disorder), altered mental status, epilepsy, dysarthria following a cerebral vascular accident (CVA, a stroke), CVA, Hemiplegia (paralysis on one side of the body), retention of urine, repeated falls, need for assistance with personal cares, muscle weakness, abnormal gait, atrial fibrillation, hypertension, weakness, lack of coordination, dependence on wheelchair, and difficulty in walking. Record review of Resident 61's Quarterly MDS dated [DATE] revealed a BIMS of 12, which indicated a moderate cognitive impairment. Section GG revealed Resident 61 can walk 10 feet and required partial to moderate assist, which indicated a helper lifted or held resident's truck or limbs and provided less than half the effort. Section GG revealed Resident 61's transfers required supervision or touching assist, which indicated a helper provided verbal cues and/or touching and/or contact guard assistance as the resident completed the activity. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Facility Incident Report dated 11/5/23 reveald the following statement: This nurse was notified that resident fell at 7:50 AM. When walking into the room a Certified Nurses' Aide (CNA) and Registered Nurse (RN) were with the patient on the floor. Resident's head was bleeding above his right eyebrow and the RN was holding pressure. Vital signs were taken, and the results were: blood pressure-153/109, heart rate-89, temperature-97.7, and respiratory rate-20. Resident's pupils were equal and reactive. Right eye appears to have a broken blood vessel. Right cheekbone looked swollen, and the right eyebrow bleeding stopped. Patient is alert and oriented. When asked where we were resident stated, the hospital. When asked the date resident answered the 5th (correct date). When asked the year resident stated, 1950 . wait no 20 . Primary physician was called and ordered resident to be sent out via 911. 911 was called and arrived at the facility at 8:15 AM. Resident was taken to Immanuel Hospital; report was called to the RN in the emergency room (ER) of Immanuel Hospital. Residents' family was notified. Director of Nursing (DON) was notified. According to the Facility Incident report dated 11/5/23 Resident 61 reported (gender) was getting up then fell and hit (gender) head on the floor. Record review of After Visit Summary from Immanuel Hospital admission which occurred from 11/5/23-11/7/23 revealed a primary diagnosis of Subdural Hematoma (a collection of blood that forms on the surface of the brain), open wound of the face, high sodium levels, ground level fall, taking blood thinners, and blurred vision. Record review of Policy entitled Reporting alleged Violations of Abuse, Neglect, exploitation or Mistreatment revealed: Procedure: In response to allegations of abuse, neglect, exploitation, or mistreatment, the Facility will: 1. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately but: -Not later than 2 hours after the allegation is made if the events that cause the allegation involves abuse or results in serious bodily injury. -Not later than 24 hours if the events that cause the allegation does not involve abuse and does not result in serious bodily injury. 2. Ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported to: A. The administrator of the facility B. The state survey agency C. Adult Protective services (as appropriate). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Ensure that, after receipt of a report of possible abuse, neglect, mistreatment, exploitation, or misappropriation of resident property, steps are immediately taken to protect the identified resident(s). 4. Ensure that he results of all investigations are reported within 5 working days of the incident to: A. The administrator B. The state survey Agency. Interview on 05/01/24 at 09:39 AM with the Facility Administrator confirmed no record of the fall incident could be found that the incident was reported to APS.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45614 Licensure Reference Number 12-006.05(5) Based on record review and interview the facility failed to notify 1(Resident 43's and Resident 43's family representative) of 1 sampled in writing of the resident's transfer to the hospital. The facility had a census of 73. Findings are: A record review of Resident 43's Minimum Data Sheet (MDS a federally mandated assessment tool used for care planning) dated 3/24/2024 revealed Resident 43 had a Brief Interview for Mental Status (BIMS) of 15 which indicated the resident is cognitively intact. Resident 43 had the following diagnoses: Neuroleptic induced Parkinsonism, Unspecified Convulsions, Schizoaffective Disorder, Depressive type, Schizoaffective Disorder, Bipolar Type, Anxiety Disorder, unspecified, Cognitive Communication Deficit and generalized Muscle Weakness. Resident 43 did not want to be interviewed. A record review of Resident 43's Clinical Census Sheet revealed Resident 43 was transferred to the hospital on 11/27/2023. A record review of Resident 43's electronic health record did not reveal a written notice of transfer/discharge for resident's hospitalization on [DATE]. An interview on 05/01/2024 at 2:58 PM with the facility Administrator confirmed the facility could not produce transfer/discharge documentation for Resident 43's hospitalization on [DATE].

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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. 50106 Licensure Reference Number 175 NAC 12-006.09D1C Based on record review, interview, and observation, the facility failed to provide bathing per resident preference for 1(Resident 4) of 3 sampled residents. The facility identified a census of 73. Findings are: Record review of the facility policy labeled Policy/Procedure-Nursing Services dated 5/2022. Section: Showers/bathing. Subject: Shower, Bed bath, and Sponge Bathing revealed the following: It is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. Procedure: 1. Showers, bed baths, and sponge baths will be provided to residents in accordance with the resident's shower schedule or preferences. 2. If a resident is unable to showered on their scheduled day related to room changes or appointments, will attempt to reschedule. 3. Showers, bed baths, and sponge baths will be documented in the medical record/POC. Refusals will also be documented. Record review of Resident 4's Significant Change Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 4/25/24 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) a score of 15. According to the MDS manual, a score of 15 indicated the resident's cognition was intact. Review of section GG of the MDS revealed Resident 4 was dependent on staff for bathing/showering and personal hygiene. Record review of Resident 4's Care Plan dated 4/25/2020 revealed a focus of Activity of Daily Living (ADL) Self Care Performance Deficit related to disease process, obesity, cognitive impairment, and knee pain. The goal of this care plan focus is ADL needs will be met daily with staff assistance. The intervention for bathing was as follows: Bathing: (Resident 4 stated) I prefer to take a shower and need assist of one. Observation of Resident 4 on 4/29/24 at 3:24 PM revealed Resident 4's hair was uncombed and greasy. On 4/29/2024 at 3:24 PM an interview was conducted with Resident 4. During the interview Resident 4 stated I haven't had a shower in 2 weeks. Record review of Resident 4's showering/bathing electronic record revealed Resident 4 received showers on 4/5, 4/9, 4/13, 4/21, and 4/22. Resident 4 did not receive a shower between 4/22 and 5/1, a total of nine days lapsed between showers. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Keystone Ridge Post Acute Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 7501 Keystone Drive Omaha, NE 68134	

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A interview was conducted on 05/01/24 at 8:50 AM with the Director of Nursing (DON). During the interview the DON confirms Resident 4 had not received a shower two times a week per resident preference.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49164 License Reference Number 175 NAC 12.006.04C2 Based on record review and interview the facility failed to ensure a Registered Nurse (RN) was present in the facility for at least 8 consecutive hours on 03-31-2024 and 4-28-2024, which had the potential to affect all residents that reside in the facility. The facility census was 73. Findings are: Record review of the facility's Daily Nursing Daily Deployment sheets revealed there was not a RN present in the facility for 8 consecutive hours on 03-31-2024 and 04-28-2024. Record review of the facility's Nurse Staffing Hours posting revealed there was not a RN present in the facility for 8 consecutive hours on 03-31-2024 and 04-28-2024. An interview conducted with the Administrator (ADM) on 05-02-2024 at 1:06 PM who confirmed there was not a RN working for 8 consecutive hours on 03-31-2024 and 04-28-2024.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 50683 Licensure Reference Number 175 NAC 12-006.11D Based on observation, interviews, and facility documentation review, the facility failed to prepare and serve food that is palatable, attractive and at a safe and appetizing temperature. This failure could place all residents who received food prepared in the facility kitchen at increased risk of exposure to food-borne illnesses. Total census was 73 and potentially affected all 73 residents. Observation on 5/01/2024 at 9:10 AM revealed Cook -E was preparing lunch meal for the facility residents. Cook -E had previously placed ham in 4 different pans and was observed adding brown sugar and pineapple on top of each ham. Cook -E placed foil over the top of the pans with ham and placed the ham into the oven. Cook -E performed hand hygiene for 12 seconds and applied gloves. Cook-E opened four (4) boxes of diced potatoes and took the bags of diced potatoes out of the box and placed them on the prep table. Cook-E opened a bag of diced potatoes and dumped them in a large bowl and then sprinkled them with garlic seasoning, pepper, parsley flakes, onion powder, liquid butter and salt. No measurements of any spices or butter was completed. Cook-E placed the paper liner on a baking sheet and pushed the paper liner down on the baking sheet with a soiled glove. Cook -E sprayed [NAME] (a cooking spray) on the baking sheet and poured the potatoes onto the pan and covered them with foil with Cook-E repeated this same process for the remaining 3 bags of potatoes. Cook-E removed their gloves, put spices away after wiping the spice containers and the counter with a sanitizer wipe. Cook-E obtained five (5) cans of corn and opened them with a attached can opened, obtained other spices and applied gloves without the benefit of hand hygiene. Cook-E obtained four (4) cooking pans and placed one can of corn into each pan. Cook-E added the 5th can of corn and added 8 cups of corn into two (2) of the pans. Cook-E put approximately 1/2 tablespoon of salt in each pan and squeezed an unmeasured amount of liquid butter into each pan. Cook-E filled the liquid butter bottle, removed gloves, and placed foil on top of the pans, put masking tape on top of pan to label. Cook -E placed the potatoes that were on baking sheets on a wheeled rack cart and placed in the refrigerator. Cook -E placed the corn into the over and performed hand hygiene for 10 seconds. At 10:00 AM Cook-E took the ham out of the oven, washed hands for 5 seconds and then put gloves on. Cook-E obtained the temperature of the ham which was at 162 degrees for 15 seconds, re-covered the ham with foil and placed back into the oven. Cook -E lowered the oven temperature to 180 degrees to keep the ham warm. An interview on 5/01/2024 at 9:40 AM with Cook-E revealed that the corn recipe was for 133 residents. Cook-E confirmed there were 73 residents in the facility and that they were all receiving the lunch meal out of this kitchen. There were no other options different serving sizes. Cook-E reported that is hard to determine how much ingredients and spices to put in when you have to make the corn in four different pans. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	B. On 5/01/2024 Cook-F left the kitchen at 11:47 AM and returned at kitchen at 12:04 PM. Cook-F spoke to residents who were present in the dining room to get their meal choices and then lined up meal tickets. Cook -F performed hand hygiene for 12 seconds, applied gloves, prepared a plate, wiped off a dirty cart with a rag and changed gloves without performing hand hygiene. Cook -F dished 5 more plates and at 12:08 PM with the same soiled gloves on took the cart to the dining room and served those residents who were at different tables. In the main dining room, the Certified Dietary Manager (CDM) loudly cued Cook -F to serve all residents at one table then move on and asked why the cook had gloves on. The CDM reminded Cook -F to wash hands with glove changes. Cook -F returned to the kitchen, applied gloves without completing hand hygiene and plated 6 more plates of food and took them to the dining room at 12:21 PM. Cook-F returned to kitchen and removed gloves and performed hand hygiene for 18 seconds and put on new gloves. Cook -F continued to touch clean and dirty surfaces with gloves on including touching a serving counter (dirty surface) and then touch serving ladles and then touching the inside of serving bowls with soiled gloves. C. An observation of the meal being served on 5/01/2024 from 11:40 AM to 12:42 PM revealed Cook -F was preparing room trays out of the main kitchen. Room trays were dished first and placed into a wheeled multi-rack kitchen tray serving cart. A Test tray that had been requested was plated and put into serving cart at 11:45 AM. Test tray delivered to the conference room on 5/01/2024 at 11:47 AM with the CDM using the facility thermometer revealed the food temperatures were as followed: -Ham 102 degrees. -Ground Ham 104.1 degrees. -Diced potatoes 98.4 degrees. -Corn 106 degrees. On 5/01/2024 at 11:47 AM an interview was completed with the CDM. During the interview the CDM confirmed the food did not reach 135 degrees and confirmed the ham and potato's were cold. An interview on 5/02/2024 at 7:55 AM with the CDM confirmed the facility uses RD Dining Menu and it is for 133 servings. CDM also confirmed that the cook should have mixed the potatoes in a large tote and followed the recipe. Review of the Nebraska Food Code, Section 3-501.19 revealed: (1) The FOOD shall have an initial temperature of 5 C (41 F) or less when removed from cold holding temperature control, or 57 C (135 F) or greater when removed from hot holding temperature control; P

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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** 50683 Licensure Reference Number 175 NAC 12-006.11E Based on observation, interviews, and facility documentation review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions in accordance with professional standards for food service safety, in that foods were kept past their expiration date, and foods were not labels or dated when they were opened. The facility failed to ensure the food equipment and food preparation areas are clean and sanitized. This failure could place residents who received food prepared in the facility kitchen at increased risk of exposure to food-borne illnesses. Total census was 73 and potentially affected all 73 residents. Findings are: A. During the initial tour of the kitchen 4/29/2024 from 1:05 PM to 1:55 PM revealed the following; -There was a buildup of grease on the floor in the dish room with dirt and food crumbs, a cup on the floor under a storage rack and cups lying in a tin all stacked together. -The floor behind and beside the oven area had grease build up with food debris and visible dirt stuck to it. -There were small bowls and small plates stacked face up on a tray on the shelf by the wash sink. While staff washing their hands in the wash sink, it was observed that water splash from the wash sink, splattered water onto these small bowls and small plates. -There were three (3) trays with dark, dry substances on this shelf with other plates and bowls. Two (2) plates and one (1) bowl with dried food debris on them. -Dishes and cooking equipment stored on a wired rack cart that had dust and rust on it. A wired rack, near the food prep counter, had three (3) loaves of bread, one (1) canister of opened oatmeal, a personal lunch box, a personal cell phone, and menus with clean pots and pans. -The meat slicer stored on the lower shelf was visibly dirty with large amount of dried old food particles. -Another wired rack, next to the other rack, had a large box of bananas and 14 bottles of syrup on a blue tray. -Several small steam tray pans turned upside down directly on the food rack which had visible food debris. These small steam tray pans were later used to serve food in. -On a blue tray there were observed a three (3) hole puncher, along with a bottle of Vanilla and an outdated bottle of green food coloring dated 2/22/2020. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Two (2) woks were dirty with old food crumbs. On the top shelf of this rack were one (1) lamp with 2 extension cords. The Certified Dietary Manager (CDM) reported that the lamp and extension cords are used when they have to look into the walk- in freezer as the light did not work. -The floor by the oven revealed a drain that had grease, dirt and other unidentified substances all around it. -The flour bin had an open paper bag of undated flour in it along with 2 Styrofoam cups and dish towels lined the bottom of the bin. Dust and a spilled dark, dry, substances were observed on the large prep table along with a square storage container of what looked like grape jelly but had no label, and a roll of toilet paper. -The shelf below the large prep table observed with cutting board stacked on it had a dried purple substance along with food crumbs and dust on it. -The floor the large prep table below with corrosion and a metal box covered with rust. A utensil rack hanging above a prep table revealed an Emerald lanyard with a key hanging on in direct contact with a food strainer. A large floor mixer had four (4) walkie-talkies laying on the shelf it was sitting on. -A prep cart with wheels revealed dried, sticky substance on the bottom shelf with a butter knife lying on it. Two (2) large cooking pots had dust on them. -The prep table with the microwave on it with food debris, food crumbs and dust on the bottom shelf. A large shop vac was sitting on the floor beside the stove and directly across from a food prep area. - The three (3) compartment sink was dirty with splattered food and water stains. The counter attached to the three-compartment sink had dried food debris on it along with four (4) bags of what appeared to be frozen chili. An observation at 1:35 PM on 4/29/2024 revealed a dietary staff member taking the trash out on a cart and returned to the kitchen without cleaning the cart, the dietary staff member took the cart into the dry storage room and loaded boxes of food for meal prep. The back up chest freezer located near the dry storage room had 9 boxes of bread on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Dry Storage Room revealed several bottles of bleach on the shelves below other food items. A different shelf had a large bottle of Lime Away, a cleaning caddy with an open bottle of Windex, a can of rust blaster, and 2 bottles of [NAME] protein hair conditioner. One (1) bottle of spray hand sanitizer, 1 can of Comet, 1 can of wasp spray, 1 large jug of multi quat solution on the cart beside food. Wrappers and dirt observed on the floor under the shelves. A personal black jacket hanging on a cart that smelled of smoke. A thick red substance noted on the wall above the food in the dry storage room. Inside the upright refrigerator there were 2 cups of poke cake not covered and not dated. The cart beside the refrigerator showed a coffee maker that had buildup on the floor below of dirt and grime. The walk-in freezer revealed a large amount of ice buildup inside and outside of the freezer door. The freezer door did not close completely; a large vacant space noted below the freezer door which allowed room air to come in, which resulted in a thick layer of ice on the inside of the freezer door and ice on the bottom of the outside of the freezer door. The freezer door jam had a black wire on it, which the CDM reported the light switch and wire caught on fire a while back and it doesn't work. There were pancakes in the freezer with ice on them. Record Review of the Daily Cleaning Duties in the kitchen for April 2024 revealed the following were cleaned 2 days out of the month of April: -Oven Face, Sides, and Top Scrubbed Clean -Flour/Sugar Bins Cleaned -Can Opener Cleaned -Hand Sink Cleaned/Soap and Paper Towels Full -Grill trap emptied/Fryer Cleaned, and Grease Fresh (It is to note that facility does not have a fryer). An observation in the kitchen on 4/29/2024 at 3:05 PM revealed a chest freezer located near the dry storage room with excessive frost on all sides and on the rim of the freezer. One thermometer inside the chest freezer read negative 10 degrees and another thermometer inside the chest freezer read negative 20 degrees. The following items were in the freezer: -1 bag of what looked like chicken patties with freezer burn and had no label or date. -1/4 bag of chicken wings that had a buildup of ice on them with no date and label. -1 bag of Canadian bacon dated 07/02 with no year had a large amount of freezer ice all over it. - 2 Sysco sliced corned beef with pack dated 10/05/2022, freeze by date of 12/19/2022 had large amount of freezer ice all over the package. - 1 bag of frozen hot dogs dated 02/22/2023 that were discolored and with ice buildup on them. An observation on 4/29/2024 at 1:20 PM with the CDM revealed all the above listed items were not clean, sealed, labeled, and/or dated. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview on 5/01/2024 at 12:15 PM with Cook -E about cleaning schedule in the kitchen revealed that there is a cleaning log for the kitchen and copies were obtained. Cook-E reported that it is difficult to deep clean the kitchen floor without functioning drains on the floor. An interview with Maintenance Director (MD) on 5/02/2024 at 10:24 AM confirmed that the floor drains in the kitchen had not been working and approximately 2 weeks ago a plumber was called in and snaked all the kitchen floor drains and added an additional cover over the floor drain next to the oven. Maintenance Director confirmed that all drains have been working now for 2 weeks. Maintenance Director (MD) verified that the metal box located under the food prep table that was covered with rust, grease and food debris was a junction box. An interview with the CDM on 4/29/2024 at 1:20 PM confirmed that the facility had ordered a new freezer door before COVID and it didn't get installed due to COVID because the company who had ordered the door gave it to another facility.The CDM confirmed that It's been years since requesting a new freezer door. The CDM confirmed the CDM observed and confirmed the above listed items were not clean, sealed, labeled, and/or dated and should have been. B. An observation of meal service on 5/2/24 at 8:04 AM in the Garden Cafe dining room revealed CDM arrived with food cart for the Garden Cafe. The CDM placed 3 medium size pans in the steamer,2 small pans on top of steam tray and 1 large pan on top of the cart.The CDM proceeded to make coffee and Dietary Aide (DA)-G without a hair net on, entered the dining room and performed hand hygiene for 6 seconds. DA-G was observed touching resident plates with bare hands. After [NAME] goves, DA-G put a steam tray lid on top of the bread and cups. While scooping food, DA-G leaned over the cart with their sweatshirt and fanny pack touching the clean plates. DA-G did not refer to any meal tickets while serving the residents in the dining room and instead hollered across the dining room to ask the residents what they wanted to eat, touched the coffee cake with soiled gloves. Four meal plates were dished, and DA-G delivered them to the residents at their table. DA-G stopped to wrap silverware in napkins then continued to serve meals with same soiled gloves on. DA-G without removing the soiled gloves and completing hand hygiene touch the coffee cake that was being served to the residents. Sugar packets for a resident was obtained by DA-G obtained sugar packets and with the same soiled gloves poured the sugar onto a resident's cereal. DA-G continued to touch plates in center of plate and then served food on those plates with the same soiled gloves. DA-G placed soiled gloved fingers in bowls, used the soiled gloved fingers to put eggs, sausage and coffee cake into a bowl from a plate and used the same soiled gloved fingers to tear up the sausage.The DA -G continued to serve plates to residents with the same soiled gloves. DA-G removed gloves and opened sugar packets to put in cereal bowl for a resident without completing hand hygiene. DA-G applied new gloves without performing hand hygiene, sorted through the meal tickets with gloves on to see if everyone in the dining room had been served.The DA-G placed the meal tickets on the trays on the room tray cart and removed gloves and their sweatshirt. DA-G hand hygiene was performed for 7 seconds and new gloves applied. DA -G started to plate room trays at 8:35 AM and while filling plates DA-G obtained toast with soiled gloves on that was being served to residents. DA-G prepared drinks for the cart for the residents in their rooms, removed the soiled gloves gloves,wiped sweat from forehead with a paper towel and performed hand hygiene for 7 seconds. DA-G finished pouring drinks and then stopped to wrap silverware for resident use. A interview was conducted with Resident #20 on 5/02/2024 at 9:33 AM. During the interview Resident #20 reported the ground sausage was ice cold and they would not eat the eggs because they are never good. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An interview with CDM on 5/02/2024 at 11:45 AM confirmed the concerns with hand hygiene and gloving and cross contamination in the Garden Cafe Dining Room. C. Record review of the facility undated policy titled Infection Control Prevention and Control Program- Hand Hygiene under the Policy revealed, This facility considers hand hygiene the primary means to prevent the spread of infections. The policy also stated that Use an alcohol-based hand rub containing at least 62% alcohol: or alternatively, soap (antimicrobial or non-antimicrobial) and water . which included Before and after eating or handling food. According to the Centers for Disease Control (CDC) Hand Hygiene in Health-Care Settings (2022) at https://www.cdc.gov/mmwr/PDF/rr/rr5116.pdf revealed the following: -When washing hands with soap and water, wet hands first with water, apply an amount of product recommended by the manufacturer to hands, and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Review of the Nebraska Food Code, Section 3-501.19 revealed: (1) The FOOD shall have an initial temperature of 5 C (41 F) or less when removed from cold holding temperature control, or 57 C (135 F) or greater when removed from hot holding temperature control; P.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 50106 Based on record review and interview the facility failed to maintain staff documentation of offering the COVID 19 vaccine, education on COVID 19 vaccine, and the current Covid 19 vaccination status of 1 of 1 staff record audited. This has the potential to affect all the current residents in the facility. The facility reported a census of 73. Findings are: Record review of CNA-A personnel record revealed no record of the facility offering the COVID 19 vaccine, education on the COVID 19 vaccine, or record of current COVID vaccination status. Record review of policy entitled: Immunization Staff. Policy-The facility has established a process for staff immunizations based on: The CDC ACIP State or local health department The intent is to help reduce the risk of staff contracting and spreading influenza or SAR-COVID to reduce the chance of staff contracting Hepatitis B from exposure to blood or other contaminated sources, and as part of wound management. The facility will educate staff on the risks and benefits for the specific vaccines, offer to administer vaccine(s) and report vaccination data to the CDC National Healthcare Safety Network and/or state/local agencies as required. Interview on 4/30/24 at 3:40 PM with the Director of Nursing (DON) revealed staff are offered the Hepatitis B vaccine series, influenza vaccine, and the COVID 19 vaccine. Interview on 05/02/24 at 10:39 AM with the DON confirmed no education, screening, or records of COVID vaccine for the staff could be found.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have enough outside ventilation via a window or mechanical ventilation, or both. 17285 Licensure Reference Number 175 12-007.04D Based on observation and interview, the facility failed to ensure that ventilation systems were operational in resident bathrooms in 6 (rooms 5116, 5119, 5121, 5124, 5126, and 5128) of 43 occupied rooms in the facility. The facility census was 73. Findings are: Observation on 5/2/24 between 08:00 AM to 9:15 AM with the facility Maintenance Director revealed that the ventilation system was not functional and would not draw a 1 ply square of toilet paper to the surface of the ventilation cover in resident bathrooms in resident rooms 5116, 5119, 5121, 5124, 5126, and 5128. Interview on 05/2/24 at 09:15 AM with the Maintenance Director confirmed that the ventilation system did not draw a 1 square ply of toilet paper in resident bathrooms 5116, 5119, 5121, 5124, 5126, and 5128. The Maintenance Director confirmed that the ventilation system had not been for draw and that there was no documentation of when the last time the system had been checked to ensure it was operational.