STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285249	A. Building B. Wing	08/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Joseph's Villa, Inc.	927 Seventh Street David City, NE 68632

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0657 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(F)The facility failed to put in new interventions in the comprehensive care plan to prevent falls for 2 (Resident 2 and Resident 6) out of 3 sampled residents. The facility census was 52.Licensure Reference Number 175 NAC 12-006.09(F) A record review of the admission Record revealed Resident 2 was admitted to the facility on [DATE] with diagnoses of Adult failure to thrive (a collection of symptoms that include weight loss, decreased appetite, fatigue, and cognitive decline), Diarrhea (frequent, loose, or watery bowel movements), Constipation (a condition where bowel movements are infrequent or difficult to pass, often characterized by hard, dry stools), Urinary tract infections (an infection in any part of the urinary system), insomnia (trouble falling asleep, staying asleep (usually through the night), or waking up too early in the morning), Arial fibrillation (a heart condition where the heart beats irregularly and rapidly), and Hypothyroidism (when your thyroid gland doesn't make and release enough hormone into your bloodstream).A record review of the Minimum Data Set (MDS) (A comprehensive assessment of each residents functional capabilities) with an Assessment Reference Date of 5/28/2025 revealed Resident 2 had 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 15 which indicates Resident 2 is cognitively intact. Resident 2 requires supervision or touching assistance with activities of daily living (ADL's).A record review of Resident 2 progress notes revealed:-On 12/12/24 Resident 2 had a fall when (gender) slid out of bed. Resident 2 had gripper socks on. Vital signs were taken and assisted off the floor with no assessment of what the resident was doing prior to fall.-On 1/12/25 -per report from a Nursing Assistant (CNA) Resident 2 is needing more assistance with ADL's.-On 1/13/25 Resident 2 had a fall at 4:58 PM when (gender) trying to make the bed. -On 7/7/25 Resident 2 had a fall. Resident 2 floor was wet and was wearing (genders) gripper socks. Vital signs taken and assisted off the floor with no assessment of what the resident was doing prior to fall.A record review of Resident 2 Care Plan revealed that Resident 2 is at risk for falls related to gait/balance problems and hearing/vision problems. The care plan revealed that interventions for Resident 2 falls:-12/12/24 - intervention was to assist resident out of bed each morning.-1/13/25 - intervention for fall was to make Resident 2 bed before 10 AM. -7/7/25 -intervention was to Please assist resident to bed between 8-830 pm. be sure resident is wearing gripper socks or non-slip foot ware at all times while out of bed. There had been no new or revised interventions that had been put in place for the falls on 12/12/24, 1/13/25, and 7/7/25. A record review of the Fall Prevention Program with policy revised date of 12/2/19 revealed:7. Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care: a) Interventions will be monitored for effectiveness, b) the plan of care will be revised as needed. An interview on 7/11/25 at 2:30 PM with the Director of Nursing (DON) confirmed that the interventions for Resident 2 falls had not been revised or new interventions put in place and new/revised interventions should have been put in place on the care plan. B.A record review of the admission Record revealed Resident 6 was admitted to the facility on [DATE] with the diagnosis of Altered mental status (a change in a person's level of awareness, alertness, or cognitive function), pain, depression (a persistent state of low mood and aversion to activity that can significantly interfere with daily life), fracture of the left femur (thigh) and humerus (upper arm), and weakness (lack of physical or muscle strength, or a feeling of being tired and having low energy).A record review of the Minimum Data Set (MDS) (A comprehensive assessment of each residents functional capabilities) with an Assessment Reference Date of 5/23/2025 revealed Resident 6 had 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 00 which indicates Resident 6 is severely impaired. Resident 6 requires one assist with activities of daily living (ADL's).A record review of the progress notes for Resident 6 revealed:-On 12/11/24 Resident 6 was observed on the floor in Resident 6's room. Vitals signs taken and was assisted off the floor, with no assessment of what the resident was doing prior to fall.-On 2/9/25 Resident 6 was observed on the floor in Resident 6 room. Vitals signs taken and assisted back up off the floor, with no assessment of what the resident was doing prior to fall.-On 4/21/25 Resident 6 was observed on the floor in Resident 6 room. Vitals signs taken and assisted back up off the floor, with no assessment of what the resident was doing prior to fall.-On 4/22/25 Resident 6 was observed on floor between the water sink in room and the bathroom in Resident 6 room. Vitals signs taken and assisted back

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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** License Reference Number 175 NAC 12-006.09 (H)(iv)(5)The facility failed to monitor bowel status and administer PRN meds to prevent constipation for three residents (Resident 2, 41 and 52) out of six sampled residents. The facility census was 52.Findings: A. A record review of Resident 41’s “Minimum Data Set” (MDS)(this comprehensive assessment evaluates each resident's functional capabilities) dated 4/28/2025 revealed a brief interview for mental status (BIMS) score of 13 which indicated the resident’s cognitive function is considered intact and Resident 41 was dependent for toileting. A record review of Resident 41’s “Care Plan” dated 8/6/2025 revealed a diagnosis of constipation without interventions associated with prevention of constipation. A record review of Resident 41’s “Bowel Monitoring Form” dated 4/1/2025-8/12/2025 revealed no bowel movements documented 4/13/2025-4/18/2025 (six days no bowel movement), 5/3/2025-5/8/2025 (six days no bowel movement), 5/25/2025-6/4/2025 (11 days no bowel movement), 6/8/2025-6/11/2025 (four days no bowel movement), 6/29/2025-7/3/2025 (five days no bowel movement), 7/26/2025-7/29/2025 (four days no bowel movement), and 7/31/2025-8/4/2025 (5 days no bowel movement). A record review of Resident 41’s “Medication Administration Record” dated May, June, July, and August 2025 revealed no bowel medications had been administered. A record review of Resident 41’s current orders revealed: · Bowel protocol day two: four ounces of prune juice every day as needed for bowel management. · Bowel protocol day three: Sennosides Tablet 8.6 milligrams (MG), give two tablets by mouth every 24 hours as needed for bowel management. · Bowel protocol day four: Milk of Magnesia 30 milliliters (ML) by mouth every 24 hours as needed for bowel management · Dulcolax Rectal Suppository 10 MG, insert one suppository rectally every 24 hours as needed for bowel management. A record review of the Facility’s Bowel Care Protocol with a revision date of 10/22/2024 revealed: a. Day two of no bowel movement- four ounces of prune juice. b. Day three of no bowel movement- Senna 8.6 two tabs every day. c. Day four of no bowel movement- Milk of Magnesia 30 ML every day. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	d. Day five of no bowel movement- Dulcolax Suppository every day. e. If no results, contact the Physician to update on client’s bowel status, may request routine bowel medications or enema administration. A record review of the Facility's Bowel Movement policy dated 4/29/2011 and a revision date of 10/22/2024 revealed: The nurse aide will document the resident's bowel movements each shift for their assigned residents on the medication record. 1. All staff will observe cognitively impaired residents for behaviors that could indicate need to evacuate bowels, i.e. restlessness, digging in rectum, agitation, a continuous oozing of diarrheal stool, etc. These behaviors will be reported to the Cart Nurse for follow up. 2. The night nurse will review the current medication administration record to identify the number of days each resident has not had a bowel movement. Medication aides/Cart Nurse on day shift will double check. 3. The nurse will document all residents identified as not having a bowel movement for two or more days on the Bowel movement (BM) list. The BM list will be attached to each halls report sheet. 4 Residents on the BM list will be assessed by the charge nurse for individual bowel schedule, possible side effects from pain meds, bowel sounds, and impaction. 5. If the resident has been identified, the Cart Nurse will notify the Physician, office nurse, and DON. In interview on 8/11/2025 at 10:49 AM with MA-C confirmed the night shift runs the bowel report for the residents and the charge nurse monitors the BM list. An interview on 8/11/2025 at 10:50 AM with LPN-D confirmed the bowel report is run by the night shift and the results are communicated to the day shift. “There is a bowel protocol that the nurses follow on day two, three, and day four”. LPN-D confirmed there were no bowel medications administered to Resident 41 during the days of 5/25/2025-6/4/2025. An interview on 8/11/2025 at 10:58 AM with the DON confirmed the bowel protocol: · Day one of no bowel movement requires no intervention. · Day two, three, and four of no bowel movement, there is a protocol. The night nurse makes up the bowel list and reports to day shift for follow up. An Interview on 8/11/2025 at 10:58 AM with the DON confirmed no bowel medications were administered to Resident 41 during the days of 5/25/2025-6/4/2025. The DON confirmed no bowel movement documented for resident 41 during the days of 5/25/2025-6/4/2025 and should have had follow up. B. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the admission Record revealed Resident 2 was admitted to the facility on [DATE] with diagnoses of Adult failure to thrive (a collection of symptoms that include weight loss, decreased appetite, fatigue, and cognitive decline), Diarrhea (frequent, loose, or watery bowel movements), Constipation (a condition where bowel movements are infrequent or difficult to pass, often characterized by hard, dry stools), Urinary tract infections (an infection in any part of the urinary system), insomnia (trouble falling asleep, staying asleep (usually through the night), or waking up too early in the morning), Arial fibrillation (a heart condition where the heart beats irregularly and rapidly, and Hypothyroidism (when your thyroid gland doesn't make and release enough hormone into your bloodstream). A record review of the Minimum Data Set (MDS) (A comprehensive assessment of each residents functional capabilities) with an Assessment Reference Date of 5/28/2025 revealed Resident 2 had 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 15 which indicates Resident 2 is cognitively intact. Resident 2 requires Supervision or touching assistance with activities of daily living (ADL's). An interview on 8/6/25 at 9:30 AM with Resident 2 revealed that Resident 2 states (gender) have issues with constipation. A record review of nursing assistant task for Resident 2 revealed that April 26th through 5/1/25 there was nothing marked for bowel movements (BM's). A record review of nursing assistant task for Resident 2 revealed 5/4/25 through 5/7/25 no BM was recorded, 5/9/25 through 5/13/25 no BM was Recorded 5/16/25 through 5/19/25 no BM was recorded. A record review of nursing assistant task for Resident 2 revealed 6/1/25 through 6/4/25 no BM was recorded, and 6/12/25 through 6/19/25 no BM was recorded. A record review of the nursing assistant task for Resident 2 revealed 7/15/25 through 7/22/25 no BM was recorded. A record review for the April 2025 medication administration record revealed no PRN's(as needed) for Bowel care had been given A record review for the May 2025Medication administration record revealed no PRN's for Bowel Care had been given A record review for the June 2025 Medication administration record revealed no PRNs for Bowel Care had been given A record review for the July 2025 Medication administration record revealed no PRN;s for Bowel care had been given A record review of the Physicians orders revealed Bowel management orders for Prune juice 4 ounces daily as needed for bowel management , Dulcolax suppository 10 mg (a unit of mass, often used in measuring small quantities of substance, including medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rectally as needed every 24 hours for bowel management, Milk of Magnesia (MOM) Suspension 400 mg/5ml give 30 ml by mouth every 24 hours as needed for bowel management, Senna 8.6 mg tablet give 2 tablets as needed every 24 hours for bowel management. A Record review of the facility Bowel Movements policy dated 4-29-2011 revealed Bowel Care Protocol a. On day two of no bowel movement-4oz of prune Juice every day c. On day three of no bowel movement-Senna 8.6-2 mg tabs every day d. On day four of no bowel movement -30cc MOM every day e. On day five of no bowel movement -Dulcolax Suppository every day f. If no results, contact the physician to update on clients= bowel status, may request routine bowel medications or enema administration An interview on 8/11/25 at 11:45 AM with the Director of Nursing (DON) confirmed that the bowel management program should have been followed with Resident 2 and it wasn't. DON confirmed that no PRN bowel medications was given to Resident 2 in the months of April, May, June and July 2025 and it should have been. The DON confirmed that the physician had not been contacted when Resident 2 had gone over 5 days of no bowel movements. C. A record review of Resident 52’s admission record dated 08/06/2025 revealed that the resident was admitted to the facility on [DATE]. A record review of Resident 52’s medical diagnosis printed on 08/12/2025 revealed a primary diagnosis of unspecified dementia (a usually progressive condition marked by the development of multiple cognitive deficits such as memory impairment, aphasia [a loss or impairment of the power to use or comprehend words usually resulting from brain damage], and the inability to plan and initiate complex behavior), generalized muscle weakness, and anxiety disorder (an abnormal and overwhelming sense of apprehension and fear often marked by physical signs, by doubt concerning the reality and nature of the threat, and by self-doubt about one's capacity to cope with it.), restlessness, agitation, and repeated falls. A record review of Resident 52’s “Minimum Data Set” (MDS, a federally mandated comprehensive assessment tool used to determine a resident’s functional capabilities and assists nursing home staff identify health problems) dated 07/04/2025 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 3 indicating severe cognitive impairment. A record review of Resident 52’s MDS section GG revealed that the resident is dependent on staff for all toileting and is unable to walk to the bathroom and in Section H, Bladder and Bowels, revealed that the resident is always incontinent of bowels. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 52’s Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident’s medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) printed on 08/06/2025 revealed no mention of risk for constipation or interventions to avoid constipation. A record review of facility Bowel Movements” policy dated 04/29/2011 revealed “Bowel Care Protocol a. On day two of no bowel movement-4oz of Prune Juice Q (every) Day. c. On day three of no bowel movement-Senna 8.6-2 tabs Q Day. d. On day four of no bowel movement 30cc (cubic centimeters) of MOM (Milk of Magnesia) Q Day. e. On day five of no bowel movement -Dulcolax Suppository Q Day. f. If no results, contact the physician to update on clients= bowel status, may request routine bowel medications or enema administration.”. A record review of Resident 52’s “Task: Bowel and Bladder (B&B) Bowel Elimination” report printed 08/07/2025, revealed that the staff charted that the resident had no bowel movements (BMs) between the following dates: 05/31/2025 to 06/06/2025. 06/12/2025 to 06/20/2025. 07/01/2025 to 07/10/2025. 07/13/2025 to 07/21/2025. 07/25/2025 to 07/26/2025. 07/28/2025 to 08/2/2025. A record review of Resident 52’s “Medication Administration Record” (MAR) dated June, July and August 2025 revealed prescribed PRN (as needed) bowel medications: Polyethylene Glycol 3350 (MiraLAX) 17 GM (grams)/scoop given orally every 24 hours as needed for bowel management. Senna 8.6 MG (milligrams) give 2 tabs every 24 hours for bowel management. Milk of Magnesia (MOM) 400 MG/5ML (milliliter) every 24 hours are needed for constipation. Bisacodyl Suppository 10MG every 24 hours as needed for bowel management. (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 Resident 52’s MAR dated June, July, and August 2025 revealed no PRN bowel medication was given for constipation. In an interview on 08/11/2025 at 11:24AM with Registered Nurse (RN)-G confirmed that the facility does have a bowel protocol but has never had to use it. RN-G reported that a different resident did receive MOM over the weekend as reported by the night nurse, so RN-G followed up to see if the medication was effective. RN-G reported that the night nurse is to run the list of residents on the bowel list and inform oncoming day nurse so that they can provide the needed PRN bowel medications. In an interview on 08/11/2025 at 12:15 with the Director of Nursing (DON), confirmed that no PRN bowel medications were administered during the months of June, July, and August of 2025 and should have been given, and confirmed that Resident 52’s bowel elimination report revealed that no BMs were charted for the following dates: 05/31/2025 to 06/06/2025. 06/12/2025 to 06/20/2025. 07/01/2025 to 07/10/2025. 07/13/2025 to 07/21/2025. 07/25/2025 to 07/26/2025. 07/28/2025 to 08/2/2025.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 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(I)Based on observation, interview, and record review, the facility failed to implement interventions (action taken to improve the situation) to prevent potential falls for 1 (Resident 42) of 3 sampled residents. The facility census was 52.Findings are: A record review of the facility's Fall Prevention Program dated 02/28/2025 revealed that when a resident had a fall, the facility would review the resident's care plan and add an intervention before the end of the shift. The resident's risk factors and environmental hazards would be evaluated when developing the resident's care plan and interventions would be monitored for effectiveness. The care plan would be revised as needed. A record review of Resident 42's Clinical Census dated 08/11/2025 revealed the resident was admitted to the facility on [DATE].A record review of Resident 42's Medical Diagnosis dated 08/11/2025 revealed the resident had diagnoses of Paranoid Schizophrenia (delusions and seeing things), Morbid Obesity (very overweight), Attention-Deficit Hyperactivity Disorder (ADHD)(trouble paying attention), Anxiety, and Depression.A record review of Resident 42's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 078/15/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 9 which indicated the resident was moderately cognitively impaired. The resident was independent for eating, needed supervision with oral hygiene (cleaning), needed substantial/maximal assistance with dressing, footwear, toileting, and personal hygiene, and dependent of staff for bathing. The resident's fall history for 6 months before the MDS was blank and the resident had not fallen since the last MDS.A record review of the facility's Incidents By Incident Type report dated 09/05/2025 - 08/06/2025 revealed Resident 42 had fallen on 10/17/2024, 10/23/2024, 10/24/2024, 11/04/2024, 11/06/2024, 11/08/2024, 11/10/2024, 11/10/2024, 11/11/2024, 12/14/2024, 12/27/2024, 01/04/2025, 01/14/2025, 02/20/2025, 03/30/2025, and 04/16/2025.A record review of Resident 42's Post Fall Huddle Form dated 10/24/2024 revealed the resident fell on that date at 10:35 AM and all interventions were in place at the time of the fall. The resident fell because the resident was dizzy and hungry. The new intervention was move closer to nurse's station and offer snack between meals. The staff emailed the Director of Nursing (DON) regarding fall and new intervention. A record review of Resident 42's Care Plan with an admission date of 07/10/2024 revealed the resident had a focus area of the resident being at risk for falls related to poor balance, poor communication/comprehension (ability to convey and understand information). The resident had one intervention for the 10/24/2025 fall and that was to move the resident closer to the nurse's station.A record review of Resident 42's Electronic Medical Record did not reveal that the resident or the resident's family had refused to change resident rooms. An observation on 08/07/2025 at 1:50 PM revealed Resident 42 was sleeping in resident room [ROOM NUMBER] which was the last room on the [NAME] side of the [NAME] hallway.An observation on 08/11/2025 at 7:40 AM revealed Resident 42 was sleeping in resident room [ROOM NUMBER] which was the last room on the East side of the East hallway which was approximately 129 feet from the nurse's station.An observation on 08/11/2025 at 11:48 AM revealed Resident 42 was sleeping in resident room [ROOM NUMBER] which was the last room on the [NAME] side of the [NAME] hallway.In an interview on 08/11/2025 at 1:46 PM, the facility's Social Worker (SW) confirmed on 07/10/2024 Resident 42 was in room [ROOM NUMBER]A, on 10/25/2025/ the resident was moved to bed B in room [ROOM NUMBER] which was further from the nurse's station, and on 06/27/2025 the resident was moved to room [ROOM NUMBER], bed A which again further from the nurse's station. The SW confirmed it was not documented that the resident or the resident's family refused a room change closer to the nurse's station.In an interview on 08/11/2025 at 2:25 PM, the MDS Coordinator (MDS) confirmed that the intervention for Resident 42's 10/24/2025 fall was to move the resident closer to the nurse's station and that was not done. MDS confirmed MDS was not sure why the staff thought that would have been a good intervention anyway because there was only 1 semi-private room that would have worked, and the resident was Medicaid and couldn't afford a private room.In an interview on 08/12/2025 at 7:40 AM the facility's Administrator confirmed the intervention for the 10/24/2025 was to move Resident 42 closer to the nurse's station and the facility staff did not. The Administrator was unsure why the staff used that as an intervention for the 10/24/2025 fall because there was not a room for the resident at the time.

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St. Joseph's Villa, Inc.	927 Seventh Street David City, NE 68632

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)(vi)(3)(g)Based on observation, interview, and record review, the facility failed to ensure 1 (Resident 53) of 1 sampled resident's oxygen order was followed. The facility census was 52.Findings are:A record review of the facility's Oxygen Concentrator policy dated 8/11/2025 revealed oxygen was to be administered under order of the physician. The nurse would verify the orders for the flow rate and turn the unit on to the desired flow rate.A record review of the facility's Oxygen Administration policy dated 8/11/2025 revealed oxygen was administered consistent with professional standards of practice. Oxygen was administered under the orders of a physician.A record review of Resident 53's Clinical Census dated 08/11/2025 revealed the resident was admitted to the facility on [DATE].A record review of Resident 53's Medical Diagnosis dated 08/11/2025 revealed the resident had diagnoses of Chronic Respiratory Failure (long term breathing disorder resulting in low oxygen), Hypoxemia (low oxygen in the blood), Obstructive Sleep Apnea (stop breathing during sleep), and Williams syndrome (a genetic disorder that causes developmental delays). A record review of Resident 53's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 04/25/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) that was blank. The resident needed supervision with eating, partial/moderate assistance with oral hygiene (cleaning) and dependent on staff for toileting, bathing, dressing, footwear, and personal hygiene. The resident was on oxygen.A record review of Resident 53's Care Plan with an admission date of 07/23/2024 revealed the resident had a focus area of the resident being at risk for ineffective breathing and an intervention to administer oxygen as prescribed. A record review of Resident 53's Order Summary Report dated 08/11/2025 revealed the resident had an order of oxygen at 2 liters per minute (l/m) per nasal cannula (a tube that goes in the nose to deliver oxygen) at all times as needed for saturations (oxygen in blood) below 88 percent (%), ordered on 07/15/2025. A record review of Resident 53's Weights and (&) Vitals dated 08/11/2025 at 11:53 AM revealed the resident's oxygen saturation on 08/11/2025 at 8:07 AM was 88% with oxygen on via nasal cannula. An observation on 08/06/2025 at 9:14 AM revealed Resident 53 was lying in bed in the resident's room and the oxygen concentrator (a machine used to purify oxygen) was set at 3 l/m. An observation on 08/11/2025 at 11:15 AM revealed Resident 53 was sitting on the bed in the resident's room with the nasal cannula laying on the floor and the oxygen concentrator was running and set at 3 l/m. Three different staff members walked by and looked at the resident between 11:15 AM and 11:40 AM and none of them asked the resident to put the oxygen nasal cannula on. At 11:40 AM the facility's Social Worker (SW) entered the room and assisted the resident to the dining room and the resident did not have oxygen on. An observation on 08/11/2025 at 11:47 AM - 12:01 PM revealed Resident 53 was seated in the dining room without oxygen on and breathing through the mouth. An observation on 08/11/2025 at 12:01 PM with Registered Nurse (RN)-G revealed following: being asked if the resident should be on oxygen, RN-G tested Resident 53's oxygen saturation and the resident's oxygen saturation was 83% on Room Air. RN-G got the resident's concentrator from the resident's room and took it to the dining room and placed the nasal cannula on the resident. The oxygen concentrator was set at 3 l/m.An observation on 08/11/2025 at 1:37 PM with RN-G revealed Resident 53 was lying in bed in the resident room with the oxygen on at 3 l/m. In an interview on 08/11/2025 at 1:37 PM, RN-G confirmed Resident 53's oxygen saturation at 12:01 PM was 83% on room air and the resident should have been on oxygen. RN-G confirmed the oxygen concentrator was set a 3 l/m and the order was for 2 l/m, so RN-G decreased the oxygen to 2 l/m.

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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. (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number: 175 NAC 12.004.02 Based on observation, interview, and record review, the facility failed to ensure staff performed proper hand hygiene during food preparation and between glove changes, ensure expired foods were discarded, ensure food brought in by family was labeled and dated, and ensure staff food was stored separately from residents' food in the unit refrigerators to prevent potential foodborne illness. This had the potential to affect all 52 residents in the facility who consume food prepared in the kitchen.A.An observation during the initial kitchen tour on 8/6/2025 from 8:20 AM to 9:25 AM revealed the following:One box of thickened hot cocoa mix with expiration date 5/4/2025.Two bottles of honey thickener with expiration date 6/6/2025.Upright freezer with an open bag of chicken strips not dated or sealed.In the dry storage, two totes of Panko breadcrumbs opened 5/6/2025 with no expiration date found, and six boxes of chicken noodle soup with expiration date of 4/2025.An interview with the Dietary manager (DM) on 8/6/25 at 8:27 AM confirmed the expired items and the breadcrumbs did not have an expiration date. An observation of the supplement refrigerator located on [NAME] Hall on 8/6/2025 at 9:25 AM revealed the following:One meat and cheese sandwich dated 3/2/25.An unlabeled and undated opened chocolate snack pack pudding. An unlabeled and undated slice of pizza and chicken wings, with a staff name on it.Two bottles of grape jelly stuck to the shelf, with expiration dates of 10/24/2023 and 1/22/2025. One Yoplait yogurt with an expiration date of April 22, 2025, which belonged to a resident. One bottle of prune juice with an expiration date of 1/3/25.An undated and unlabeled opened container of apple sauce. An observation of the supplement refrigerator located on [NAME] Hall further revealed dried spilled liquids and food on shelving and sticky substances on the top door shelf and drawer. An interview with the DM on 8/6/2025 at 9:37 AM confirmed the uncleanliness of the refrigerator, the undated /unlabeled items, staff food in the refrigerator, expired items and the DM verbalized that they would probably not serve the sandwich. A record review of the temperature log / cleaning log located on the front of the refrigerator revealed under the column indicating if the refrigerator was cleaned the staff had written in no for the first five days of August. An observation of the Locked Unit supplement refrigerator on 8/6/2025 at 9:37 AM revealed the following:Two bags of beef jerky sticks labeled with a resident's name, no date noted on package.One cup of small cherry tomatoes labeled MM with no dates.One jar of peach halves labeled with a first name on it and no dates. One unlabeled and undated container of small tomatoes. One bottle Hershey's syrup with an expiration date of 2/2025.One Boost Breeze nutritional drink with an expiration date of 7/11/2025.Six snack bags of strawberry Chex Mix with expiration dates of 6/11/2025.Four snack bags of regular Chex Mix with expiration dates of 7/2025.One opened bag Tostitos not sealed and marked opened 5/2025.Staff food (Great Value mayonnaise, Melissa's BBQ sauce, Tostitos queso dip) stored with residents' food. An interview with the DM on 8/6/2025 at 9:50 AM confirmed the outdated items and resident/staff food without label and dates. A Record review of the facility policy Use and Storage and Food Brought in by Family or Visitors last revised 3/3/21 under #2. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator. The prepared food must be consumed by the residents within 3 days. If not consumed within 3 days, food will be thrown away by facility staff. B.An observation of food preparation on 8/7/2025 at 9:32 AM, with the Registered Dietitian (RD) present, revealed [NAME] 1 performing hand hygiene for 30 seconds, applied gloves, prepared onions, and discarded scraps. After removing gloves, the cook performed hand hygiene for 45 seconds. The cook then measured eggs, meat, breadcrumbs, tomato paste, Worcestershire sauce, minced garlic, Italian seasoning, salt, and pepper and placed the items into a mixing bowl. Without performing hand hygiene, the cook applied gloves and mixed the ingredients by hand. After removing the gloves, the cook applied non-stick spray to a pan liner and then applied new gloves without performing hand hygiene and pressed the meat mixture into the cooking pan with gloved hands. The pan was covered with foil and placed in the oven. An interview on 8/7/2025 at 10:00 AM with the (RD) confirmed the cook should have performed hand hygiene before both glove applications when handling the meat mixture. An interview on 8/7/2025 at 11:00 AM, with the DM and RD confirmed there was no system for labeling food brought in by family or discarding old resident food. An interview on 8/12/2025 at 9:12 AM, with the DM confirmed all 52 residents consume food prepared in the facility's 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18(B) Licensure Reference Number 175 NAC 12-006.18(D) The facility failed to sanitize the blood glucose monitoring machine prior to and after obtaining a blood sugar on three (Resident 41, 43. and Resident 50) out of three sampled residents, perform proper hand hygiene while administering medications, keep Resident 53's oxygen nasal cannula off the floor and concentrator filter clean to prevent potential cross contamination. The facility census was 52. Findings are: Findings: A. A record review of the Facility’s “Glucometer Disinfection” policy dated 19/2000 with a review date of 6/2025 revealed: The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected, the meter should not be used for multiple patients. The glucometers should be disinfected with a wipe pre-saturated with an Environmental Protection Agency (EPA) registered healthcare disinfectant that is effective against Human Immunodeficiency Virus (HIV), Hepatitis C, and Hepatitis B virus. Glucometers should be cleaned and disinfected after each use and according to manufacturer’s instructions regardless of whether they are intended for single resident or multiple resident use. Procedure: a. Obtain needed equipment and supplies b. Wash hands c. Explain procedure to the resident d. Provide privacy e. Put on gloves f. Obtain blood sampling g. Remove and discard gloves, perform hand hygiene prior to exiting room. h. Reapply gloves if needed i. Retrieve two disinfectant wipes from container. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. Using first wipe, clean first to remove heavy soil. k. After cleaning, use second wipe to disinfect the glucometer machine thoroughly with the disinfectant wipe, following the manufacturer’s instructions. l. Discard disinfectant wipe in the waste receptacle. m. Perform hand hygiene A record review of the Facility’s undated “Hand Hygiene” policy revealed: 1. Staff will perform hand hygiene when indicated, using proper technique consistent with acceptable standards of practice. 2. Additional considerations: the use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. An observation on 8/07/2025 at 10:59 AM revealed LPN-E obtaining a blood sugar on Resident 41 without sanitizing the blood glucose monitoring machine prior to or after obtaining the blood sugar. An observation on 8/07/2025 at 11:09 AM revealed LPN-E obtaining a blood sugar on Resident 9 without sanitizing the blood glucose monitoring machine prior to or after obtaining the blood sugar. Following the procedure, LPN-E removed gloves but failed to perform hand hygiene prior to leaving Resident 41’s room. An interview on 8/07/2025 at 11:24 AM with the LPN-E confirmed the glucose machine was not sanitized after Resident 41 and before Resident 9. LPN-E confirmed the glucose monitoring machine is to be sanitized between each resident use and it was not done. An observation on 8/07/2025 at 11:52 AM revealed LPN-E at medication cart preparing to give resident medications, no hand hygiene was observed. LPN-E proceeded to pull medications from the cart, checked the Electronic Medical Record (EMR), popped medications into a cup from the medication cassette, scooped pudding into a cup with a spoon, locked the cart, and proceeded to walk down the hall to a resident room. LPN-E entered resident room without performing hand hygiene, administered the medication to the resident, placed resident’s legs up on the foot pedals, moved the resident to a different location in the room, placed resident’s feet back on floor, and returned the foot pedals to the up position. LPN-E left the room without performing hand hygiene. LPN-E returned to the medication cart, proceeded to look through the EMR, no hand hygiene was observed. An interview on 8/11/2025 at 12:37 PM with the Infection Preventionist (IP) confirmed the expectation for hand hygiene and cleaning of the glucose monitoring machine: 1. Washing hands in between residents or use hand sanitizer. 2. Sanitize glucose monitoring machine between residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. An observation on 8/7/2025 at 11:15 AM revealed Medication Aide (MA-A) was observed standing beside Resident 43 preparing to poke the resident’s finger without gloves on. MA-A stopped, picked up supplies, and went to the medication cart, stating, “I forgot, the resident has their own device.” The MA-A then looked in the computer and stated, “It needs to be replaced so I will need to poke the resident’s finger. MA-A then performed hand hygiene using hand sanitizer, applied gloves, returned to the resident, wiped the resident’s finger with an alcohol pad, used a lancet to puncture the finger, wiped away the first drop of blood, and obtained a sample. The glucometer displayed a reading of “E13,” so the MA-A obtained new supplies and repeated the process, which resulted in a reading of “338.”MA-A placed the glucometer on the medication cart, walked to a cupboard, obtained a Sani cloth germicidal wipe and wiped the device for 8 seconds before placing it back into the cart. A Record review on 8/7/2025 at 11:22AM with MA-A of the Sani cloth germicidal wipe container revealed that the manufacturer’s recommendation required A two-minute wet period on the surface of the equipment to sanitize it. An interview on 8/7/2025 at 11:24AM with MA-A confirmed that the germicidal wipe was not in contact with the glucometer for 2 minutes and MA-A responded, “I didn’t know about a 2 minute wet time. ” C. A record review of the facility's “Oxygen Concentrator (a machine used to purify oxygen)” policy dated 8/11/2025 revealed the staff was to follow manufacturer’s instructions for cleaning the filter, change the nasal cannula (a tube that goes in the nose to deliver oxygen) monthly and if it becomes contaminated (infected or dirty), and keep the oxygen delivery devices in a plastic bag when not in use. A record review of the facility’s “Oxygen Administration” policy dated 8/11/2025 revealed the staff was to follow manufacturer’s instructions for cleaning the filter, change the nasal cannula monthly and if it becomes contaminated, and keep the oxygen delivery devices in a black cloth bag when not in use. A record review of the “AirSep Newlife Elite Patient Manual” dated 03/02 revealed the air intake filter on the back of the oxygen concentrator should be cleaned weekly. https://oxygenalliance.org/wp-content/uploads/2024/03/AirSep-NewLife-Elite-Patient-Manual.pdf A record review of Resident 53’s “Clinical Census” dated 08/11/2025 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 53’s “Medical Diagnosis” dated 08/11/2025 revealed the resident had diagnoses of Chronic Respiratory Failure (long term breathing disorder resulting in low oxygen), Hypoxemia (low oxygen in the blood), Obstructive Sleep Apnea (stop breathing during sleep), and Williams syndrome (a genetic disorder that causes developmental delays). (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	A record review of Resident 53's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 04/25/2025 revealed the resident had a Brief Interview for Mental Status (BIMS)(a score of a resident’s cognitive abilities) that was blank. The resident needed supervision with eating, partial/moderate assistance with oral hygiene (cleaning) and dependent on staff for toileting, bathing, dressing, footwear, and personal hygiene. The resident was on oxygen. A record review of Resident 53’s “Care Plan” with an admission date of 07/23/2024 revealed the resident had a focus area of the resident being at risk for ineffective breathing and an intervention to administer oxygen as prescribed. A record review of Resident 53’s “Order Summary Report” dated 08/11/2025 revealed the resident had an order of oxygen at 2 liters per minute (l/m) per nasal cannula (a tube that goes in the nose to deliver oxygen) at all times as needed for saturations (oxygen in blood) below 88 percent (%), ordered on 07/15/2025. An observation on 08/06/2025 at 9:14 AM revealed Resident 53 was lying in bed in the resident’s room and the AirSep Newlife oxygen concentrator was set at 3 l/m and the resident had a nasal cannula in the nose. The filter on the back of the machine had a thick coating of a gray fuzzy substance on it. An observation on 08/11/2025 at 11:15 AM revealed Resident 53 was sitting on the bed in the resident’s room with the nasal cannula laying on the floor and the AirSep Newlife oxygen concentrator was running and set at 3 l/m and the filter on the back had a gray fuzzy substance on it. Three different staff members walked by and looked at the resident between 11:15 AM and 11:40 AM and none of them asked the resident to put the oxygen nasal cannula on. At 11:40 AM the facility’s Social Worker (SW) entered the room and assisted the resident to the dining room and the resident did not have oxygen on. An observation on 08/11/2025 at 11:47 AM - 12:01 PM revealed Resident 53 was seated in the dining room without oxygen on and breathing through the mouth. An observation on 08/11/2025 at 12:01 PM with Registered Nurse (RN)-G revealed RN-G tested Resident 53’s oxygen saturation and the resident’s oxygen saturation was 83% on Room Air. RN-G got the resident’s concentrator from the resident’s room and took it to the dining room and placed the nasal cannula on the resident. The AirSep Newlife oxygen concentrator was set at 3 l/m. The filter on the back of the oxygen concentrator had a gray fuzzy coating on it and RN-G did not clean or replace the nasal cannula that had been on the floor in the resident’s room before placing it in Resident 53’s nose. An observation on 08/11/2025 at 1:37 PM with RN-G revealed the resident was lying in bed in the resident room with the oxygen on at 3 l/m and the AirSep Newlife oxygen concentrator’s filter had a gray fuzzy coating on it. In an interview on 08/11/2025 at 1:37 PM, RN-G confirmed the resident’s saturation was 83% on room air and the resident should have been on oxygen. RN-G confirmed the oxygen concentrator filter had a fuzzy gray coating on it and RN-G cleaned the filter. RN-G confirmed the filter should have been cleaned monthly and did not appear it had been, so RN-G cleaned the filter.