

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Mother Hull Home		STREET ADDRESS, CITY, STATE, ZIP CODE 125 East 23rd Street Kearney, NE 68847	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49382 Licensure Reference Number 175 NAC 12-006.19 Based on observation and interview, the facility failed to ensure a clean and sanitary environment in resident's bathrooms for 5 (rooms 9, 11, 16, 18, and 23) of 12 sampled rooms and failed to ensure hand sanitizer dispenser was working for 1 (Resident 23) of 49 sampled residents with a facility census of 49. Findings are: In an observation completed on 12/18/2024 at 8:05 AM the following was noted: -In the bathroom of room [ROOM NUMBER] the call light box was secured to the wall of the bathroom to the left of the toilet. The porous cord hanging from the call light that the resident would use to activate the call light was yellow brown from the middle of the cord to the end of the cord. On the faucet of the sink beneath the hot and cold-water knobs there is a buildup of porous white material that has both green and black areas on top of the white material. There is yellow white flaky build up material to the bottom portion of the faucet where it is connected to the sink. -In the bathroom of room [ROOM NUMBER] the call light box was secured to the wall of the bathroom to the left of the toilet. The porous cord hanging from the call light that resident would use to activate the call light was yellow brown in color to approximately 2 inches of the cord. The light located above the sink in the bathroom had 2 light bulbs in it only one light bulb was on and functioning. On the faucet of the sink beneath the hot water knob there is a white porous buildup with green areas on top of the buildup visible. -In the bathroom of room [ROOM NUMBER] the call light box was secured to the wall of the bathroom to the left of the toilet. The porous cord hanging from the call light that resident would use to activate the call light is dark yellow in color approximately 1 inch of the cord towards the top of the cord. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-In the bathroom of room [ROOM NUMBER] the call light box is secured to the wall of the bathroom to the left of the toilet. The porous cord hanging from the call light that resident would use to activate the call light is brown fading to yellow in color for more than 1/2 of the cord in its entirety. On the faucet of the sink beneath the hot and cold-water knobs there is a buildup of porous white material that has green areas on top of the white material. -Just inside the doorway to room [ROOM NUMBER] on the right side is a hand sanitizer dispenser attached to the wall. It was observed that on 12/16/2024, 12/17/2024 and 12/18/2024 to be not functioning. When hand is placed where indicated for product to be dispensed no product is dispensed. In the bathroom the call light box was secured to the wall to the left of the toilet. The porous cord hanging from the call light that the resident would use to activate the call light is yellow brown in color in an approximate 1-inch section towards the bottom of the cord. On the faucet of the sink beneath the hot and cold-water knobs and to the right side of the faucet opening is a white porous buildup of material. On top of this build up beneath the hot water knob is green in color also. In an interview completed on 12/18/2024 at 8:30 AM with the Maintenance Supervisor, Housekeeping Supervisor, and Facility Administrator it was confirmed that the call light cords in bathrooms of rooms 9, 11, 16, 18, and 23 were discolored, that the faucets in the bathrooms of rooms 9, 11, 18, and 23 had build up on them and the buildup was a non-cleanable surface, and room [ROOM NUMBER] bathroom light bulb was out and room [ROOM NUMBER] hand sanitizer was not working.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 Based on record reviews and interviews, the facility failed to ensure that resident assessments were coded incorrectly for hypoglycemic and antiplatelet on the Minimum Data Set (MDS, a standardized assessment tool used to comprehensively evaluate the health and functional capabilities of residents nursing homes to create individualized care plans based on their specific needs) . This affected 2 residents (Residents 6 and 12) of 3 sampled residents. The facility census was 49. Findings are: A. Record review of the Physician Orders reviewed on 12/16/2024 for Resident 6 revealed an order for Humalog insulin subcutaneous three times daily before meals and once at bedtime given on a sliding scale based on Resident 6's blood sugar. The physician orders also revealed an order for Levemir 12 units subcutaneous at bedtime. Record review of the MDS dated [DATE] for Resident 6 revealed the resident had a diagnosis of diabetes. Section N (Medications) subsection N0300 this resident received injections 7 days a week and in subsection N0350 that this resident received insulin injections 7 days a week. In subsection N0415 the use of hypoglycemic was not checked and indication was not noted. This information is required to provide resident specific information for payment and quality measure purposes. Interview on 12/17/2024 at 11:45 AM with the Minimum Data Set Coordinator (MDS) revealed this information is reviewed quarterly for each resident and then the resident care plan is updated. There is a specific look back period of time to review medications when creating the MDS. Interview on 12/17/2024 at 11:50 AM with MDS who (delete who) confirmed that this information for hypoglycemic was encoded incorrectly in Section N subsection N0415. B. Record Review of the Physician Orders printed on 12/12/2024 for Resident 12 revealed an order for Aspirin delayed release 81 milligram tablet once daily. (Aspirin is a medication with antiplatelet properties). Record review of the MDS data report dated 9/26/2024 for Resident 12 revealed that the resident had diagnoses of anemia, atrial fibrillation, and coronary heart disease. The MDS also revealed in Section N subsection N0415 that the resident was taking an antipsychotic, an antidepressant, and an anticoagulant. Interview on 12/17/2024 at 11:50 with MDS who confirmed that aspirin is an antiplatelet and not an anticoagulant and the MDS subsection N0415 was coded incorrectly.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50253 Licensure Reference Number 12-006.09(H)(iii) Based on record reviews, interviews, and observations, the facility failed to ensure interventions for constipation were put into place to promote bowel movements for 2 (Residents 6, and Resident 12) of 5 sampled residents, and the facility failed to provide wound care that prevented cross contamination for 1 (Resident 14) of 1 sampled residents. The facility census was 49. Findings are: A. Record review of the undated Bowel Movement Assessment/Monitoring policy and protocol stated the purpose is to monitor bowel regularity while taking into consideration any knowledge of bowel habit history on an individual basis. The procedure included reviewing bowel and bladder records nightly and making a note as to those who had not had a Bowel Movement (BM) for 2 days. This is forwarded to the day shift nurses who would then assess for needs of a laxative. If there had been no BM by the following morning, the day shift nurse was to assess for further laxative needs. Further laxatives may be administered. Record review of the Minimum Data Set (MDS, a standardized assessment tool used to comprehensively evaluate the health and functional capabilities of residents nursing homes to create individualized care plans based on their specific needs) dated 11/24/2024 for Resident 6 revealed the resident had a BIMS (Brief Interview for Mental Status -used to assess a person's cognitive function by evaluating their orientation and short-term memory) score of 10 which indicated moderate cognitive impairment. Resident 6 had diagnoses of cancer, hypertension, anemia, heart failure, and diabetes. Record review of the Care Plan (a detailed document outlining the specific healthcare needs and services a person requires to manage their chronic illness or disability) dated 12/4/2024 for Resident 6 revealed this resident was independent with a 4 wheeled walker in the resident room and in the facility. Resident 6 was continent of bowel. Record review of the Bowel Movement output charting found that Resident 6 did not have a bowel movement during the period of 11/20/2024 and 12/16/2024. Record review of the Medication Administration Record for Resident 6 during the time period of November 17, 2024 through December 17, 2024 revealed that Resident 6 was administered Miralax (a medication for bowel regularity) on a daily basis and received Milk of Magnesia (a medication for the relief of constipation) on 11/17/2024 and 11/18/2024. Laxatives had not been administered on 11/31/2024, 12/3/2024, 12/4/2024, or 12/5/2024. Interview on 12/17/2024 at 10:30 AM with Registered Nurse (RN-B) revealed that the nurses are given a sheet every morning at report. On this sheet we (we?- is this supposed to be a quote?) see who hasn't had a bowel movement and who may need to have Milk of Magnesia or a suppository. If the resident is more than 4 days without a bowel movement, the physician may be called for further orders. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/17/2024 at 11:00 AM with the Director of Nursing confirmed that the bowel program for constipation had not been followed by the nursing staff for Resident 6. 49382 B. A review of a Resident Face Sheet dated 12/16/2024 revealed that the facility admitted Resident 12 on 08/26/2024 with diagnoses of lung cancer (which is development of a cancerous lesion in the lung), and constipation (which is the difficulty or inability to have frequent bowel movements). The comprehensive MDS dated [DATE] revealed Resident 12 had a BIMS score of 10 indicating the resident was moderately cognitively impaired. The resident was coded to be dependent on staff assistance with toilet use and transfers and the resident was always continent of bowel. Constipation being present was not coded on the MDS. Review of Resident 12's Care Plan revealed a problem of the resident requiring assistance by staff with activities of daily living including transfers and toilet use dated 08/26/24. Review of Resident 12's electronic medical health record revealed the following: -No documentation present indicating the resident had a bowel movement, intervention to promote a bowel movement, or assessment of resident due to not having a bowel movement from 10/10/2024, 10/11/2024, 10/12/2024, and 10/13/2024. -No documentation present indicating the resident had a bowel movement, intervention to promote a bowel movement, or assessment of resident due to not having a bowel movement from 10/26/2024, 10/27/2024, and 10/28/2024. -No documentation present indicating the resident had a bowel movement, intervention to promote a bowel movement, or assessment of resident due to not having a bowel movement from 11/04/2024, 11/05/2024, and 11/06/2024. -No documentation present indicating the resident had a bowel movement, intervention to promote a bowel movement, or assessment of resident due to not having a bowel movement from 11/25/2024, 11/26/2024, 11/27/2024, and 11/28/2024. -No documentation present indicating the resident had a bowel movement, intervention to promote a bowel movement, or assessment of resident due to not having a bowel movement from 12/01/2024, 12/02/2024, and 12/03/2024. -No documentation present indicating the resident had a bowel movement, intervention to promote a bowel movement, or assessment of resident due to not having a bowel movement from 12/05/2024, 12/06/2024, and 12/07/2024. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview conducted on 12/06/2024 at 3:57 PM with Licensed Practical Nurse A (LPN-A) revealed that the night shift nurse gives a list of residents that have not had a bowel movement in 48 hours or more to the day shift nurse. The day shift nurse then provides an as needed intervention to help promote a bowel movement for the resident. If that intervention is unsuccessful by 6 AM the following morning a bowel assessment is completed including listening for bowel sounds at the abdomen and a suppository is given to promote a bowel movement. LPN-A further revealed that if the resident had still not had a bowel movement by the next morning the nurse would notify the provider and director of nursing for further interventions. In an interview conducted on 12/17/2024 at 10:08 AM with the facility DON confirmed that Resident 12 had gone periods of time as listed greater than 48 hours without a documented bowel movement, intervention to promote a bowel movement, or an assessment of the resident due to not having a bowel movement. The DON confirmed it is the facility policy to provide interventions and or assessment to the resident after 48 hours of not having a bowel movement and for these to be documented in the resident's electronic medical health record. D. Review of a facility supplied policy titled Clean Dressing Change and dated 2023 revealed to cleanse the wound outward from the center of the wound. Review of a document titled Collagenase Santyl Ointment, How to Apply dated 2024 revealed to apply Santyl Ointment directly to the wound in a 2 mm (millimeter) or about the thickness of a nickel layer. A review of a Resident Face Sheet dated 12/16/2024 revealed that the facility admitted Resident 14 on 09/27/23 with diagnoses of atherosclerotic heart disease (which is when fats, cholesterol, and other substance build up on the walls of arteries), varicose veins of the lower extremity (when the veins in the legs are bulging and enlarged), and hypertension (which is high blood pressure). The comprehensive MDS dated [DATE] revealed Resident 14 had a BIMS score of 10 indicating the resident was moderately cognitively impaired. The resident was coded to have 4 venous or arterial ulcers present (which are ulcers or wounds that are caused by irregularities in blood flow and circulation). Review of Resident 14's Physician Orders dated 12/16/24 revealed an order to apply Santyl to wound on the LLE, place a non-bordered foam over top of wound and cover with edema wear once daily. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation completed on 12/17/24 at 10:43 AM with Registered Nurse B (RN-B) revealed RN-B with gloved hands opened a vial of normal saline solution and squirted the solution on to the wounds located to Resident 14 left inner lower calf. RN-B held white gauze material to the lower portion of the wound. It was observed that the normal saline solution flowed off the wound and onto the pieces of gauze. RN-B then used the piece of gauze to dab at the wound bed directly. The RN obtained more gauze pieces and again dabbed directly on the wound bed with the pieces of gauze. The RN then threw away the gauze and discarded their gloves. RN-B performed hand sanitization using an alcohol-based hand gel and applied another pair of gloves. RN-B obtained a clear medicine cup and a long-handled Q-Tip from on top of the over bed table. RN-B placed the cotton portion of the Q-Tip into the medicine cup and rolled the Q-Tip in the light cream-colored thick substance contained in the cup. RN-B applied the substance to the residents wound bed using the Q-Tip. There was no visible thickness to the layer of substance applied to the wound bed from the clear plastic medicine cup. In an interview conducted with RN-B on 12/17/24 at 11:20 AM, RN-B confirmed that the clear medicine cup contained Santyl Ointment. RN-B confirmed that they did not ensure the ointment was applied in a layer with thickness approximately of a nickel. RN-B also confirmed that they did not cleanse the wound from the inside working to the edges or outside of the wound. In an interview conducted on 12/17/2024 at 11:50 PM with the DON confirmed that the residents wound should have been cleansed from the inside and working to the outer edges. Confirmed the nurse should have checked to ensure they are applying the correct amount of ointment to the wound and should not have used the soiled gauze pads to dab at the wound after spraying the normal saline on the wound bed. The DON confirmed wound care, and topical application was not completed in compliance with facility policy.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49382 Licensure Reference Number 175 NAC 12-006.10D Based on observation, interview, and record review, the facility failed to ensure medications were administered according to the 5 rights of medication administration for 4 residents, (Resident 14, 199, 26, and 34) of 8 sampled residents. This made an error rate of 16.13 %. The facility census was 49. A. Record review of Resident 14's Physician Orders dated 12/16/24 revealed Resident 14 had a physician order to apply Diclofenac Sodium which is a topical pain relief or analgesic cream. Directions to apply 2 grams to both resident's knees and lower back three times a day. In an observation on 12/17/24 at 11:30 AM with Registered Nurse-B(RN-B) revealed RN-B with a gloved hand used their fingers to scrape a clear thick gel like substance from a clear medication cup that was sitting on Resident 14's bed side table. RN-B stated to the resident this was their pain cream and would apply it to the resident's knees. Resident 14 pulled up the pant legs of their pants above both knees and RN-B applied the ointment to the left knee and rubbed it in then obtained more of the gel from the medication cup and applied it to the right knee and rubbed it in. In an interview on 11/17/24 at 11:45 AM with RN-B, revealed that the clear medication cup contained the residents ordered Diclofenac Sodium. RN-B confirmed they did not use the measuring guide to ensure was applying the prescribed 2 grams of the Diclofenac Sodium. RN-B further confirmed that they did not follow the physician prescribed orders for the Diclofenac Sodium. B. Review of a document labeled National Library of Medicine Stat Pearls dated August 28, 2023, revealed that Levothyroxine tablets and capsules should be taken on and empty stomach at least thirty to sixty minutes prior to breakfast with a full glass of water. In an observation completed on 12/16/27 at 8:50 AM with Licensed Practical Nurse A (LPN-A) revealed LPN-A obtained a cardboard bubble pack of medications labeled Levothyroxine tablet 75 micrograms (MCG), give on tablet by mouth one time a day with Resident 199's name. LPN-A popped the tablet into a clear plastic medication cup with Resident 199's other medications and walked to where Resident 199 was sitting in the dining area at a table. On the table in front of Resident 199 was a white plate with crumbs on it, a white bowl with visible crumbs in it, and 3 glasses of different fluids all missing different amounts of fluid. The nurse handed Resident 199 the cup containing the medications, the resident lifted the cup to their mouth and ingested the medications. The nurse thanked the resident and asked if the resident wanted more to eat or if had enough to eat already. The resident stated that they had eaten all their breakfast and would finish their drinks and was full. The nurse returned to the medication cart and documented the administration of the medications in the resident's electronic medical health record. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 12/16/24 at 9:05 AM with LPN-A confirmed that the levothyroxine medication should be taken on an empty stomach prior to eating a meal. The LPN stated they did not know if the provider had given permission for the levothyroxine to be administered in an alternative manner. In an interview on 12/16/24 at 2:45 PM with the Director of Nursing (DON) confirmed that the levothyroxine medication is normally given on an empty stomach. The DON was not sure if the provider had ok'd the administration of the medication outside of recommended standards and the medication should be taken per these standards unless otherwise directed by the provider. The DON confirmed this was a medication error. 50253 C. Record review of the medication insert for Diclofenac gel (Voltaren, a nonsteroidal, anti-inflammatory medication for pain) revised July 2009 revealed the following. -Total dose should not exceed 32 grams per day, overall affected joints. -Voltaren Gel should be measured onto the enclosed dosing card to the appropriate 2 grams or 4 grams designation. -Lower extremities: Apply the gel (4 grams) to the affected area 4 times daily. Do not apply more than 16 grams daily to any one affected joint of the lower extremities. -Upper extremities: Apply the gel (2 grams) to the affected area 4 times daily. Do not apply more than 8 grams daily to any one affected joint of the upper extremities. Record review of the Care Plan (a detailed document outlining the specific healthcare needs and services a person requires to manage their chronic illness or disability) for Resident 26 revealed this resident has an alteration in comfort related to the diagnoses of musculoskeletal decline, impaired mobility, and osteoarthritis with signs and symptoms of pain. Medications were to be administered as ordered and Resident 26 had to be encouraged to request pain medications before the pain became unbearable. Record review of the Physician Orders for Resident 26 revealed an order for the use of Diclofenac Sodium gel a small amount to the left shoulder and arm with a start date of 12/09/24. Interview on 12/16/2024 at 1:15 PM with Licensed Practical Nurse (LPN-A) revealed when asked how much is used on the resident's shoulder for pain relief, LPN-A chose to look at the physician orders and stated immediately, Oh, I think we need to contact the physician to find out how much we are supposed to actually use. LPN-A revealed that there was a plastic measuring tool to measure the desired grams of medication applied each time which LPN-A had difficulty finding in the drawer. Once found, LPN-A revealed the use of approximately one inch of gel when applying onto the shoulder of Resident 26. LPN-A repeated that the order needed to be updated to let the nursing staff know exactly how much Diclofenac gel was supposed to be applied. (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 12/16/24 at 1:25 PM with the DON when asked how much Diclofenac gel is applied to Resident 26's shoulder, DON replied I guess enough to cover the area. DON confirmed the medication order needed to be more detailed and would reach out to the ordering physician and get confirmation of the dose. D. Record Review of the Minimum Data Set (MDS, a standardized assessment tool used to comprehensively evaluate the health and functional capabilities of residents nursing homes, allowing healthcare providers to create individualized care plans based on their specific needs) dated 10/17/24 for Resident 34 revealed this resident had chronic pain. Record review of the Care Plan for Resident 34 revealed this resident had an alteration in self-care and comfort related to musculoskeletal decline caused by impaired mobility, history of bursitis in the left hip, pain, weakness and deconditioning, would attempt non-pharmacological interventions for pain, and was encouraged to request pain medication before pain became unbearable. Record review of Resident 34's Physician Orders dated 12/16/24 revealed an order for Voltaren Arthritis Pain (Diclofenac Sodium) gel 1% a small amount. Apply to both wrists. May apply to lower back as needed. Interview on 12/16/2024 at 1:25 PM with the DON confirmed the medication order needed to be more detailed and would reach out to the ordering physician and get confirmation of the dose.		

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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** 41938 Licensure Reference Number 175 NAC 1-005.06(E) Licensure Reference Number 175 NAC 12-006.18(B) Based on observation, record review, and interview, the facility failed to ensure that staff wore both a gown and gloves during resident care as required for Enhanced Barrier Precautions (An infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. Precautions involve gown and glove use during high-contact resident care activities (Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or Assisting with toileting) for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition such as residents with wounds or indwelling medical devices) for 1 (Resident 201) of 3 residents sampled to prevent the potential for cross-contamination and multidrug-resistant organisms. The facility census was 49. Findings are: Record review of the facility policy titled Enhanced Barrier Precautions dated 9/18/24 revealed that it is the policy of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce the transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The section titled Prompt recognition of need revealed that all staff receive training on enhanced barrier precautions and are expected to comply with all designated precautions. Residents with any of the following will be placed on enhanced barrier precautions-wounds including surgical wounds; indwelling medical devices including urinary catheters. Make gowns and gloves available inside the resident room. Note: face protection may also be needed if performing activity with risk of splash or spray such as wound irrigation. High-contact resident care activities include: dressing, bathing, transferring, device care including urinary catheters, and wound care of any skin opening requiring a dressing. Record review of the Minimum Data Set (MDS, a mandatory comprehensive assessment tool used for care planning) dated 12/16/24 for Resident 201 revealed that Resident 201 admitted into the facility on [DATE]. The MDS revealed that Resident 201 had an indwelling urinary catheter (A flexible plastic hollow tube inserted into the bladder to continuously drain urine. An indwelling medical device.). Interview on 12/16/24 at 2:59 PM with the spouse of Resident 201 confirmed that Resident 201 has had the indwelling urinary catheter due to prostate problems and difficulty with urination. Record review of the Care Plan (a written interdisciplinary comprehensive plan detailing how to provide quality care for a resident) dated 12/16/24 for Resident 201 revealed that staff are to use enhanced barrier precautions. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/18/2024
NAME OF PROVIDER OR SUPPLIER Mother Hull Home		STREET ADDRESS, CITY, STATE, ZIP CODE 125 East 23rd Street Kearney, NE 68847	
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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 12/17/24 at 1:14 PM in the room of Resident 201 revealed that Resident 201 sat in the wheelchair in the middle of the room. A sign titled Enhanced Barrier Precautions was present on the wall just outside the resident room door. A second Enhanced Barrier Precautions sign hung on the wall just inside the room door next to the hanging container with gloves and gowns. The Enhanced Barrier Precautions signs directed that providers and staff must wear gloves and a gown for the following high-contact care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing brief or assisting with toileting, and device care or use. Nurse Aide-C (NA-C) and Nurse Aide-D (NA-D) entered the resident room with the mechanical total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own). NA-C and NA-D put on yellow protective gowns. NA-C positioned the lift in front of the resident. The lift sling was underneath the resident's back and thighs. NA-C and NA-D used the bare hands to connect the lift sling loops onto the lift bar of the total body lift. NA-C put on gloves. NA-C removed the catheter urine collection bag from the privacy cover under the wheelchair and hung it on the lift. NA-C removed and discarded the gloves and performed hand sanitization. NA-C operated the lift and Resident 201 was lifted out of the wheelchair. NA-D prevented Resident 201 from hitting objects and grabbed the resident's lift sling from behind the resident. NA-D moved behind the recliner and held onto the lift sling using the bare hands to help guide Resident 201 to the back of the recliner. Resident 201 was lowered into place in the recliner. NA-C put on gloves and moved the catheter urine collection bag from the lift and hung it on the trash can. NA-D obtained a pillow. NA-C and NA-D used the bare hands to lean Resident 201 forward in the recliner. NA-C and NA-D placed the pillow behind the back of Resident 201. NA-D removed the gown and exited the resident room. Interview on 12/18/24 at 8:39 AM with the facility Director of Nursing (DON) confirmed that staff are to wear both gown and gloves during high contact care activities for residents on Enhanced Barrier Precautions.		