| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285254 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Mother Hull Home | 125 East 23rd Street<br>Kearney, NE 68847 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Licensure Reference Number 175 NAC 12-006.11(D)Based on observation, interview, and record review the facility failed to follow approved recipes when preparing resident foods and failed to ensure food temperature was maintained for hot food at or above 135 degrees Fahrenheit. This had the potential to affect all the residents receiving food items from the kitchen. The facility census was 45.Findings are:A.A record review of a facility supplied document titled Dining Manager Garlic Roasted Chicken and dated 2026 revealed instructions to arrange chicken pieces on a paper lined baking sheet and to evenly coat the chicken with 2 tablespoons and 2 teaspoons of lemon juice. To combine 1 tablespoon of dried oregano and 1 ounce of minced garlic an evenly spread the mixture on the chicken.In an observation on 02/05/2026 at 9:35 AM Dietary [NAME] A (DC-A) placed pieces of chicken into a metal bowl. The DC then added 2 tablespoons of lemon juice into the bowl and shook in a unmeasured amount of dried oregano into the bowl. The DA then added an unmeasured amount of poultry seasoning to the bowl and used gloved hands to mix the chicken and spices together in the bowl. DC-A did not add the required amount of lemon juice, did not measure the seasonings added, and did not add the garlic to the chicken.In an interview completed on 02/05/2026 at 12:35 PM with DC-A, DC-A confirmed that they did not use the required amount of lemon juice, did not measure the seasonings, and did not add garlic to the chicken mixture.In an interview completed on 02/05/2026 at 12:36 PM with the Dietary Manager (DM), the DM confirmed that recipes should be followed for food items prepared and served by the kitchen and were not.B.A record review of a facility supplied document titled Dining Manager Beef Chili and dated 2026 revealed instructions to combine 2 pounds 3 ounces of ground beef, 2 and 3/4 ounces of onions, and 1/2 ounce of minced garlic in a large stock pot and brown. Then add 2 and 2/3rds cup diced tomatoes, 1 cup tomato sauce, 1 and 3/4's cup water, 2 tablespoons and 2 teaspoons of chili powder, 1/2 teaspoon salt, 1/8th teaspoon pepper, and 1 tablespoon and 1 teaspoon of sugar then bring the mixture to a boil. To add drained beans to the mixture and return the mixture to a boil.In an observation on 02/05/2026 at 8:53 AM DC-A used a can opener to open a 6.38 pound can of diced tomatoes. The cook the emptied part of the can of diced tomatoes into a pot. The DC then opened a 6.88 pound can of red beans and emptied a portion of the can into the pot. The cook did not measure the amount of added diced tomatoes and did not rinse the beans or measure the amount of beans added. The [NAME] then added an unmeasured amount of chili powder, garlic powder, onion powder, and white pepper into the tomato and bean mixture. The cook then covered the pot.In an observation on 02/05/2026 at 9:36 AM DA-C uncovered the pot and added an unmeasured amount of taco seasoning to the pot and an unmeasured amount to barbeque sauce to the pot.In an interview completed on 02/05/2026 at 12:35 PM with DC-A, DC-A confirmed that they did not measure the seasonings, diced tomatoes, and beans when placing them in the pot. The DC confirmed that the recipe did not call for taco seasoning or barbeque sauce to be added and they did not follow the recipe when preparing the chili.In an interview completed on 02/05/2026 at 12:36 PM with the Dietary Manager (DM), the DM confirmed that recipes should be followed for food items prepared and served by the kitchen and were not.C.A record review of a facility supplied document titled Dinning Manager Grilled Cheese Sandwich and dated 2026 revealed instructions to brush both sides of sandwiches with melted margarine.In an observation on 02/05/2026 at 11:22 AM DC-A used a<br>(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 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | container labeled butter cooking spray to spray both sides of the sandwiches. The DC did not use margarine on the sandwiches as indicated in the recipe.In an interview completed on 02/05/2026 at 12:35 PM with DC-A, DC-A confirmed that they did not use margarine on both sides of the sandwiches as directed in the recipe.In an interview completed on 02/05/2026 at 12:36 PM with the Dietary Manager (DM), the DM confirmed that recipes should be followed for food items prepared and served by the kitchen and were not.D.A record review of a facility supplied document titled Dinning Manager Grilled Zucchini and dated 2026 revealed to combine oil salt pepper in a mixture then to add the sliced zucchini and toss evenly to coat the zucchini.In an observation completed on 02/05/2026 at 10:46 AM DC-A placed pieces of sliced zucchini onto a parchment lined pan in a single layer. The cook then sprinkled a layer of poultry seasoning over the zucchini and placed the pan into the oven. The cook did not coat the zucchini in an oil salt and pepper mixture then place on the parchment lined baking sheet.In an interview completed on 02/05/2026 at 12:35 PM with DC-A, DC-A confirmed that they did not follow the directions for preparation or seasoning of the zucchini.In an interview completed on 02/05/2026 at 12:36 PM with the Dietary Manager (DM), the DM confirmed that recipes should be followed for food items prepared and served by the kitchen and were not.E.A record review of a facility policy titled Maintaining Food Temperatures and not dated revealed hot food should be kept hot at or above 135 degrees Fahrenheit.In an observation completed on 02/05/2026 at 12:35 PM it was observed that the temperature of the zucchini was 120.5 degrees Fahrenheit and the temperature of the grilled cheese sandwich was 116.4 degrees Fahrenheit.In an interview completed on 02/05/2026 at 12:35 PM with DC-A, DC-A confirmed the temperature of the zucchini and grilled cheese was not 135 degrees Fahrenheit or greater and should be.In an interview completed on 02/05/2026 at 12:36 PM with the Dietary Manager (DM), the DM confirmed the temperature of the zucchini and grilled cheese was not 135 degrees Fahrenheit or greater and should be. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Licensure Refrence Number 175 NAC 12-006.11?Based on observation, record review, and interview, the facility failed to complete hand hygiene using the approved technique during meal preparation. This had the potential to affect all of the residents receiving food stuff from the kitchen. The facility census was 45.Findings are:Record review of a facility policy titled Hand Hygiene and dated 2021 revealed staff will perform hand hygiene when indicated using proper technique consistent with accepted standards of practice. Listed under hand hygiene technique when using soap an water to dry hands thoroughly with a single use towel and use a clean towel to turn off the faucet.In an observation completed on 02/05/2026 from 8:41 AM through 12:08 AM of Dietary [NAME] A (DC-A) preparing food the following was observed:-DC-A used scissors and gloved hands to cut open plastic wrapping from raw ground beef and placed the meat into a pan. The DC-A removed their gloves from both of their hands and walked over to the sink. The cook performed hand hygiene using soap and water. DC-A shut off the water with their wet bare hands then obtained a single paper towel and dried their hands. The DC-A did not use a clean paper towel to shut off the water after drying their hands.-DC-A with gloved hands removed raw chicken from a metal bowl and placed it on a parchment lined cookie sheet. The DC-A removed their gloves from both of their hands and walked over to the sink. The cook performed hand hygiene using soap and water. DC-A shut off the water with their wet bare hands then obtained a single paper towel and dried their hands. The DC-A did not use a clean paper towel to shut off the water after drying their hands.-DC-A removed packages of frozen zucchini from the double door freezer and placed the bags in a clear square container. DC-A then placed the container with the frozen zucchini in it under cool running water. DC-A then proceeded over to the sink and performed hand hygiene using soap and water. DC-A shut off the water with their wet bare hands then obtained a single paper towel and dried their hands. The DC-A did not use a clean paper towel to shut off the water after drying their hands.-DC-A performed hand hygiene using soap and water at the sink. DC-A shut off the water with their wet bare hands then obtained a single paper towel and dried their hands. The DC-A did not use a clean paper towel to shut off the water after drying their hands. DC-A then proceeded to the prep area and applied gloves to both of their hands. DC-A then removed slices of bread and placed them on lined cookie sheets sitting on top of the prep area. The DC-A then removed their gloves from both of their hands and went to the sink. The cook performed hand hygiene using soap and water. DC-A shut off the water with their wet bare hands then obtained a single paper towel and dried their hands. The DC-A did not use a clean paper towel to shut off the water after drying their hands. In an interview completed on 02/05/2026 at 12:35 PM with DC-A, DC-A confirmed that they shut off the water with their wet hands. The DC-A confirmed that they should have dried their hands and then used a new paper towel to shut off the water and did not.In an interview completed on 02/05/2026 at 12:36 PM with the Dietary Manager (DM), the DM confirmed that DC-A did not follow the accepted procedure for performing hand hygiene and should have. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(H)Based on record reviews, observations and interviews, the facility failed to provide adequate indications for use consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals and a documented clinical rationale for administering an antipsychotic medication that is based upon an assessment of the resident's condition and therapeutic goals, and after any safer treatments have been deemed clinically contraindicated for 2 of 5 sampled residents (Resident 5 and Resident 11). The facility census was 45.Findings are:A.Record review of a facility policy titled Use of Psychotropic Medications dated 2025 revealed adequate indications for use referred to the identified documented clinical rational for administering of a medication. Also, adequate indication for use means that the medication is administered in consistence with manufacturer's recommendations and or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review of articles that are published in medical and pharmacy journals.Record review of a document titled Highlights of Prescribing Information Olanzapine and dated 2019 revealed under indications and usage for the treatment of schizophrenia and acute and maintenance treatment of manic or mixed episodes associated with bipolar one disorder. Record review of a document titled Olanzapine and dated 02/03/2026 (https://www.drugs.com/olanzapine.html) revealed the medications is an atypical antipsychotic medication that is used to treat adults and adolescents age [AGE] and older with schizophrenia or bipolar one disorder. Record review of a Resident Face Sheet revealed the facility admitted Resident 5 on 12/18/2025 with diagnoses of depression (a common serious mood disorder characterized by persistent sadness, loss of interest in activities, fatigue, and physical pain), and anxiety disorder (a mental health condition characterized by persistent, excessive, and irrational fear or worry that interferes with daily life. Record review of Resident 5 Medication Administration Record (MAR) for the Month of January 2026 revealed the resident was administered the medication of Olanzapine (an antipsychotic medication) 2.5 milligrams every day at bedtime for an indication/diagnosis of anxiety disorder.Record review of a facility supplied document titled Note to attending Physician/Prescribe and dated 09/17/2025 revealed documentation that Resident 5 was receiving the medication of Olanzapine and lacked an acceptable diagnosis to support its' use. It was stated that documented clinical rational to support the other use for the medication should be supplied. The provider wrote the corelating code for the indication/diagnosis of anxiety disorder and did not document any clinical rational for this decision.In an interview completed on 02/09/2026 at 3:20 PM with the facility Director of Nursing (DON), the DON confirmed that the indication/diagnosis or anxiety was not an approved use of the medication. The DON confirmed that the provider wrote the code for the anxiety disorder and did not provide clinical rational for this decision.B.A record review of an undated policy titled, Use of Psychotropic Medication(s) reveal: It is the intent of this policy to ensure that the residents only receive psychotropic medication when other nonpharmacological interventions are clinically contraindicated. Additionally, these medication should only be used to treat the residents' medical symptoms and not used for discipline or staff convenience, which would deem it a chemical restraint.Definitions, adequate indications for use refers to the identified, documented clinical rationale for administering a medication that is based upon assessment of the resident's condition and therapeutic goals and after any other treatments have been deemed clinically contraindicated. For psychotropic medications, without documentation in the record explaining that the practitioner has determined that other treatments have been deemed clinically contraindicated, the indication for use is inadequate.8. Prior to initiating or increasing a psychotropic medication, the resident, family, and/or (continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident representative must be informed of the benefits, risks, and alternatives for the medication.9. The resident and/or the resident representative has the right to accept or decline the initiation or increase of a psychotropic medication.10. The facility will document that the resident or the resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and the preferred option to accept or decline in a format the facility deems to use (e.g., written consent form, narrative note, etc.).A record review of Resident 11's undated face sheet reveals an admit date of 9/07/2016. Further review reveals current diagnoses listed:-Localization-related (focal) (partial) symptomatic epilepsy (recurrent seizures originating from a specific, identifiable brain lesion or region)-Parkinson's disease with dyskinesia (a progressive, incurable neurodegenerative disorder with involuntary, erratic, writhing, or jerky movements)-Unspecified dementia with behavioral disturbance (a cognitive decline of unknown type or severity accompanied by behavioral symptoms like agitation, aggression, or wandering)-Aphasia (loss or impairment of the power to use or comprehend words usually resulting from brain damage)-Major depressive disorder (a serious mood disorder involving one or more episodes of intense psychological depression or loss of interest or pleasure that lasts two or more weeks and is accompanied by irritability, fatigue, poor concentration, sleep disturbances, weight gain or loss, feelings of worthlessness or guilt, and sometimes suicidal tendencies)-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) A record review of Resident 11's Physician Orders revealed an order, dated 07/09/2025 for olanzapine (an atypical antipsychotic) tablet 2.5 milligram (mg) amount, 1 tablet once a day. Special instructions-Target behavior: yelling. Diagnosis: unspecified dementia with behavioral disturbance. A record review of a Medication Regimen Review (MRR, includes medication reconciliation, a review of all medications a resident is currently using, and a review of the drug regimen to identify, and if possible, prevent potential clinically significant medication adverse consequences) dated 08/06/2025 revealed a request for a Gradual Dose Reduction (GDR, Stepwise tapering of a dose to determine whether or not symptoms, conditions, or risks can be managed by a lower dose or whether or not the dose or medication can be discontinued) for Resident 11 taking olanzapine tablet 2.5 mg amount, 1 tablet once a day. The facility noted, Resident 11 has recently had an increase in agitation and behaviors of wanting to leave facility (not able to verbalize where (gender) is planning to go). Staff is usually able to redirect after 30-60 minutes. A record review of Resident 11's Physician Orders revealed an order, dated 08/11/2025 for olanzapine tablet 2.5 mg amount, 1 tablet twice a day. Special instructions-Target behavior: yelling. Diagnosis: unspecified dementia with behavioral disturbance. A record review of Resident 11's Progress Notes dated 1/15/2026 showed the facility placed a call to resident's representative and left message on answering machine regarding resident being on olanzapine which started 8/11/25 with the reason for use as a behavioral impairment. Resident and resident representative informed of risk and benefits of medication and given. They understand that they can refuse or withdraw consent of medication at any time by informing staff. An interview on 2/09/26 at 2:30 PM with Licensed Practical Nurse (LPN)-B reveal monitoring for use of medications happen through daily vitals and ,just knowing the resident. A record review of an article from, American Geriatrics Society 2023 updated AGS Beers Criteria(R) for Potentially Inappropriate Medication Use in Older Adults provides information on safely prescribing medications for older adults, https://agsjournals.onlinelibrary.[NAME].com/doi/full/10.1111/jgs.18372. The article reveal; Antipsychotics, first (typical) and second (atypical) generation which includes olanzapine rationale for inappropriate use refers to, an increased risk of stroke and greater rate of cognitive decline and mortality in persons with dementia. Additional evidence suggests an association of increased risk between antipsychotic medication and mortality independent of dementia. It is also recommended to avoid, except in Food and Drug Administration (FDA; federal agency that regulate Food, Drugs, Medical Devices, Radiation-Emitting Products, Vaccines, Blood, and Biologics, Animal and Veterinary<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Cosmetics, Tobacco Product)-approved indications such as schizophrenia (a chronic, severe mental disorder characterized by disruptions in thought, perception, emotion, and behavior, often involving hallucinations, delusions, and cognitive impairment), bipolar disease ( a chronic mental health condition characterized by intense mood swings, ranging from extreme highs (mania/hypomania) to deep lows (depression)), Parkinson disease psychosis (affects over 50% of patients, characterized by non-motor symptoms like visual hallucinations (seeing people/animals), illusions, and delusions), major depressive disorder or short term use for antiemetic (prevention of nausea/vomiting due to medication intake). |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident?s preferences and goals.<br><br>Licensure Reference Number 175 NAC 12-006.09(H)(iii)(3)Based on record review, and interview the facility failed to evaluate and monitor resident skin issues for 2 (Resident 4, and Resident 7) of 2 sampled residents. The facility census was 45.Findings are: A.<br><br>Record review of a document titled Best Practices for Wound Assessment and Documentation and dated 04/17/2025 from the Wound Care Education Institute (wcei.net/best-practices-wound-assessment-documentation) revealed wound assessment and documentation serve as crucial clinical tools for effective care planning, etiology, measurements, and wound characteristics to guide treatment. High-quality documentation fosters interprofessional communication and aids in tracking healing progress while aligning with care standards.<br><br>Record review of a document titled What is standard of care in wound care and dated 05/31/2022 from Wound Source (https://www.woundsource.com/blog/what-standard-care-in-wound-care) revealed to detect signs of healing progress wounds are assessed on a weekly basis and documentation of a wound assessment is a vital component of the standard of wound care and contributes to improved patient safety, outcomes, and care quality.<br><br>B. Record review of a Resident Face Sheet revealed the facility admitted Resident 4 on 01/06/2026 with diagnosis of second-degree burn (which is damage to the top and second layers of skin causing intense pain redness swelling and blistering), of the right thigh and the abdominal wall.<br><br>Record review of the comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 01/12/2026 for Resident 4 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 8 indicating the resident was moderately cognitively impaired. Resident 4's MDS was coded indicating the resident required supervision or touching assistance with eating, substantial or maximal assistance with bed mobility, and partial to moderate assistance with transfers and toilet use. The MDS was also coded in the skin conditions section indicating that the resident had burns and was receiving application of nonsurgical dressings and applications of ointments and medications.<br><br>Record review of Resident 4's Care Plan dated 1/06/2026 revealed a problem listed of the resident having alteration in skin integrity due to burns. A goal was listed as the alteration in the skin integrity would be resolved without signs or symptoms of infection with a target date of 04/23/2026. Approaches were listed to monitor the site for signs and symptoms of infection and to notify the physician as indicated, reposition as ordered, take nutrition supplement as ordered, and to administer treatments as ordered all dated 01/06/2026.<br><br>Record review of a facility document titled admission Skin Assessment for Resident 4 dated 01/06/2026 revealed no documentation of alterations to the resident's skin integrity over the abdomen and a dressing was located to the resident's right thigh.<br><br>Record review of Resident 4's Progress Notes revealed on 01/06/2026 Resident 4 was admitted to the facility and that dressings were removed from the resident's right thigh and abdomen. The documentation identified Resident 4's wounds were cleansed, a cream was applied and the wounds were covered with a dressing. Documentation was present on 01/07/2026 that the resident had a 0.3cmX0.4cm area of pink fragile tissue to their abdomen and three areas of burnt tissue present to<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | their right upper thigh. There were no measurements to the thigh areas with description of the tissue being yellow slough with redness and traces of black dark brown tissue. The progress notes revealed documentation that the resident received dressing changes to their burns from 01/07/2026 through 01/13/2026. The documentation listed no measurements or assessments of the wounds.<br><br>Record review of a facility supplied document titled Clinic Visit Sheet dated 01/13/2026 revealed Resident 4 was evaluated/seen at the wound clinic for their wounds.<br><br>Record review of Resident 4's Progress Notes revealed documentation on 01/20/2026 by the facility Assistant Director of Nursing (ADON) that they reviewed the residents skin integrity during a dressing change. The areas were described to have scabbing present without open areas or drainage with slight pinkness to the surrounding skin. There were no measurements present in the documentation for the areas. There was documentation in the progress notes that dressing changes were performed to the areas from 01/13/2026 through 01/20/2026. The documentation listed no measurements or assessments of the wounds.<br><br>Record review of Resident 4's Progress Notes revealed documentation on 01/26/2026 that the inner most wound of the resident's right leg/thigh was observed to have thick yellow drainage present. The progress note stated that photos were taken of the wound and the photos were sent to the wound care clinic. The response from the wound care provider was that the resident would be seen the following day.<br><br>Record review of a facility supplied document titled Clinic Visit Sheet dated 01/27/2026 revealed Resident 4 was evaluated/seen at the wound clinic for their wounds.<br><br>Record review of Resident r's Progress Notes revealed from 01/26/2026 through 02/10/2026 no documentation of wound measurements or assessments.<br><br>In an interview completed on 02/09/2026 at 9:52 AM with Licensed Practical Nurse C (LPN-C), LPN-C stated that the dressings are changed daily to Resident 4's wounds. The LPN stated that the residents' abdominal wound was resolved at this time. The LPN denied measuring the wound with dressing changes or documenting wound assessments for the residents' wounds.<br><br>In an interview completed on 02/09/2026 at 10:00 AM with LPN-B, LPN-B revealed that the ADON completed weekly wound measurements and assessments. The LPN stated that the nurses just did the dressing changes and charted the dressing changes.<br><br>In an interview on 01/09/2026 at 10:48 AM with the facility ADON, the ADON stated documentation of wounds is done by exception. The ADON stated that the expectation of the facility is to only document if there is something out of the norm/baseline for wounds. The ADON confirmed that there was no routine documentation of measurements or assessments for Resident 4's wounds.<br><br>In an interview completed on 01/09/2026 at 12:30 AM with the facility Director of Nursing (DON), the DON confirmed that there were no routine documentation or measurements or assessments for Resident 4's wounds.<br><br>C.<br><br>Record review of the Tips for Successful Wound Care Documentation dated 12/10/24 from Relias<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | education (https://www.relias.com/blog/tips-for-wound-care-documentation) revealed that all wounds must be assessed, measured, and effectively documented every seven days. Key elements to document include location, type of wound, measurement (length x width x depth), wound bed, wound edges, drainage, odor, surrounding tissue, pain, and response to care and treatment (document whether the wound has improved and list any evidence of healing).<br><br>Record review of the article Back to the Basics: Wound Assessment, Management, and Documentation dated 2022 by Wolters Kluwer Health revealed that assessment, management, and documentation are the basis of delivering evidence based wound care. Assessments should be completed at least weekly. Based on the assessment, the clinician can compare data and determine the wound's response to the treatment. Proper assessment includes location, shape, size and depth, wound base characteristics, wound edges, and the condition of the surrounding skin.<br><br>Record review of the undated facility Skin Concerns Protocol revealed that skin concerns (wounds) included excoriated buttock (open wound with removal of the outer skin layers that can be caused by rubbing of the skin), moisture related skin damage (skin breakdown caused by prolonged exposure to moisture such as sweat or urine), bruising, skin tears (a traumatic wound caused by shear, friction, or blunt force that separates the top layer of skin from the underlying tissue), blisters, and pressure ulcers (a localized wound of the skin and/or underlying tissue, usually over a bony area. A bedsore.).<br><br>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 7 dated 1/1/26 revealed that Resident 7 admitted into the facility on 7/2/25. The assessment revealed that Resident 7 is dependent on staff for toileting hygiene and rolling left and right on the bed. Resident 7 is always incontinent of bowel. Resident 7 has a diagnosis of Multiple Sclerosis (a disabling disease of the brain and spinal cord). The assessment revealed that Resident 7 had no pressure ulcers. The assessment revealed that Resident 7 had no other wounds or skin problems at the time of the assessment.<br><br>Record review of the care plan for Resident 7 dated 2/4/26 revealed a goal for the resident's skin to remain intact. Interventions included reporting any signs of my skin breaking down (sore, tender, red, or broken areas) to the charge nurse. The care plan revealed an intervention to administer medications and treatments as ordered by the physician. Monitor me for possible side effects, adverse reactions, and effectiveness.<br><br>Record review of the progress note for Resident 7 dated 1/31/26 at 11:13 AM revealed that the nurse was called into the room of Resident 7 at around 9:30 AM. Resident 7 was found to have excoriated moisture damage to an area on the buttocks measuring 8 centimeters by 10 centimeters with an open area to the right buttock. The physician was notified.<br><br>Record review of the Physician Fax Communication dated 1/31/26 for Resident 7 revealed that Resident 7 has excoriated moisture damage to an area on the buttock measuring 8 centimeters by 10 centimeters with an open area to the right buttock. The area will be cleansed and zinc (a medicinal ointment) applied twice daily and as needed until resolved. The fax was signed by the provider on 2/2/26.<br><br>Record review of the medical record for Resident 7 revealed no documentation of any wound assessments after initial identification of the wound on the right buttock on 1/31/26.<br><br>Interview on 2/9/26 at 7:48 AM with Resident 7 confirmed that on open area on the right buttock was<br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | identified recently. Resident 7 revealed that the urinary catheter leaks sometimes and that staff try to keep the resident's buttocks dry to prevent skin problems. Resident 7 confirmed that nursing staff have been applying something to the wound a couple of times a day.<br><br>Record review of the medication administration record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) for Resident 7 dated 2/9/26 for administration dates of 1/10/26 through 2/9/26 revealed the order for cleanse buttocks and apply Zinc twice a day until skin damage is resolved with a start date of 1/31/26. Administrations of the order were documented twice daily on 1/31/26, 2/2/26, 2/3/26, 2/4/26, 2/5/26, 2/6/26, 2/7/26, and 2/8/26. The administration was documented once for the AM shift on 2/9/26. Licensed Practical Nurse-B (LPN-B) documented that LPN-B administered the order on 2/4/26, 2/5/26, 2/6/26 and 2/9/26.<br><br>Interview on 2/9/26 at 8:49 AM with LPN-B confirmed that LPN-B has administered the ordered treatment to the area on the right buttock of Resident 7. LPN-B revealed that LPN-B does not measure the area of the moisture excoriation wound on the right buttock of Resident 7.<br><br>Interview on 2/9/26 at 10:48 AM with the Assistant Director of Nursing (ADON) revealed that bruising, skin tears, and moisture excoriation monitoring are charted by exception if there are issues or concerns. The ADON revealed that the ADON does weekly assessment and monitoring of any pressure ulcers but none for excoriation wounds. The ADON revealed that wound treatment is documented on the resident MAR. The ADON revealed that a progress note is created when an excoriation wound or skin tear is healed.<br><br>Interview on 2/9/26 at 12:32 PM with the facility Director of Nursing (DON) confirmed that the facility did not have documentation of assessment and monitoring of the wound on Resident 7's buttock to determine improvement or decline in the wound size or condition. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Licensure Reference Number 175 NAC 12-006.09 (H)(iii)(1) and (2)Based on observation, record review, and interview the facility failed to assess and monitor pressure related skin issues to ensure documentation of wound healing or decline for 2 residents (Resident 1 and Resident 6) of 2 sampled residents, failed to ensure the settings for a specialty low air loss mattress were at the correct setting to promote healing of a pressure related wound for 1 resident (Resident 6) of 2 sampled residents and failed to cleanse pressure related wounds per professional standards of practice to promote healing for 1 resident (Resident 6) of 2 sampled residents. The facility census was 45.Findings are:Record review of a document titled Pressure Injury Prevention Guidelines dated 2018 revealed to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries it is the policy of this facility to implement evidence-based interventions for all residents assessed at risk or who have pressure injury present. The Assistant Director of Nursing or designee will review all relevant documentation regarding skin assessments, pressure injury risks, and progression towards healing at least weekly and document a summary of findings in the medical record.Record review of a document titled Best Practices for Wound Assessment and Documentation and dated 04/17/2025 from the Wound Care Education Institute (wcei.net/best-practices-wound-assessment-documentation) revealed wound assessment and documentation serve as crucial clinical tools for effective care planning, etiology, measurements, and wound characteristics to guide treatment. High-quality documentation fosters interprofessional communication and aids in tracking healing progress while aligning with care standards.Record review of a document titled What is standard of care in wound care and dated 05/31/2022 from Wound Source (https://www.woundsource.com/blog/what-standard-care-in-wound-care) revealed to detect signs of healing progress wounds are assessed on a weekly basis and documentation of a wound assessment is a vital component of the standard of wound care and contributes to improved patient safety, outcomes, and care quality.A.Record review of a Resident Face Sheet revealed the facility admitted Resident 1 on 12/22/2025 with diagnosis pneumonia (a serious lung infection), and pulmonary hypertension (high blood pressure in the lung arteries). Record review of the comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 12/26/2025 for Resident 1 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 11 indicating the resident was cognitively intact. The MDS was coded to reflect the resident required partial to moderate assistance with eating, and substantial or maximal assistance with bed mobility, transfers, and toilet use. The resident was frequently incontinent of bowel and bladder. The resident was at risk for pressure related skin alterations and had a pressure-reducing device for their chair and bed.In an interview completed on 02/04/2026 at 10:20 AM with Resident 1, Resident 1 stated that during their stay in the facility the developed a sore on their bottom and to both of their heels.Record review of Resident 1's Progress Notes revealed the following documentation:-12/22/2025 an admission note with documentation that the resident's buttock was slightly pink.-01/05/2026 documentation stating the resident returned from provider appointment with orders to apply zinc oxide (a protective barrier cream) twice daily and as needed to the buttocks.-01/07/2026 documentation stating the resident was noted to have skin breakdown to the coccyx and right buttock. There was no documentation present of measurements or description of the skin breakdown.-01/11/2026 documentation that the resident complained to the nurse that their feet were on fire and hurt and subsequent documentation that the resident frequently requested Tylenol due to the pain. There was no documentation present that the nurse assessed or observed the residents' feet.-01/12/2026 the residents responsible party was notified of the residents' complaints of pain and that nursing staff were applying the barrier cream to a moisture related skin concern to the residents' bottom. An area measuring 6.5 centimeters<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | X 4.5 centimeters described as moisture damage to the right buttock was documented. There was no documentation present of further assessment or description of the moisture damage to the skin.-01/14/2026 the resident called their provider and requested a cream for their buttock. The providers nurse phoned the facility and was updated on the moisture related area to the residents buttock and the barrier cream that was being applied. Orders were received for the resident to be seen by the wound clinic.-01/20/2026 the resident was seen by wound clinic and received a diagnosis of stage 3 pressure related skin injury (which is a full thickness wound extending into the fat tissue appearing as a deep crater). Orders were received for treatment of the area and for residents to be on bed rest with ok to be up for one hour for meal and therapy.-01/23/2026 the Assistant Director of Nursing (ADON) was notified of skin concerns to the residents' heels. It was documented that the resident had a stage 1 pressure injury to the left heel and a deep tissue injury to the right heel. It was documented to see wound management for further details and that the provider was notified and orders for no sting barrier to be applied to the areas twice daily and zero g heel lift boots to be applied to both feet while at rest along with the air exchange mattress. Resident was also to be seen by wound care on 02/04/2026.-01/29/2026 documentation that wound data collection was completed and due to the changes in appearance in the wound to the left heel the provider was notified. No new orders were received.-02/04/2026 the resident was seen and evaluated by wound clinic. New treatment orders were received for the residents' heels and buttock.Record review of a Wound Management Detail Report for resident revealed documentation of a complete assessment of the residents right sacral/buttock wound on 01/23/2026, 01/29/2026, and 02/04/2026. Documentation was present of complete wound assessments for Resident 1's pressure related wounds to their heels on 01/23/2026, 01/29/2026, and 02/04/2026. In an interview completed on 02/09/2026 at 09:52 AM with Licensed Practical Nurse C (LPN-C), LPN-C stated that Resident 1 received wound care at the local wound clinic. The LPN stated that facility staff changed dressings daily. The LPN denied measuring the wounds with dressing changes or documenting wound assessments for the residents' wounds. In an interview completed on 02/09/2026 at 10:00 AM with LPN-B, LPN-B states that the ADON completed weekly wound measurements and assessments. The LPN stated that when an area of skin alteration if first found or observed it should be measured assessed and the ADON who does the wound care is notified. The LPN confirmed that this should be entered as a progress note in the resident's health record.In an interview on 01/09/2026 at 10:48 AM with the facility ADON, the ADON stated routine wound assessment documentation is only completed on pressure-related skin concerns. The ADON stated that there was no routine documentation present for Resident 1's wound to the sacrum/buttock due to it being deemed a moisture related skin concern until seen by the wound clinic on 01/20/2026 when the wound clinic identified the area as a pressure related skin concern.In an interview completed on 01/09/2026 at 12:30 PM with the facility Director of Nursing (DON), the DON confirmed that there were no routine documentation or measurements or assessments for Resident 1's wounds prior to 01/20/2026. The DON confirmed there was no weekly summary of findings from skin assessments made by the ADON in Resident 1's medical record as outlined in the facility policy prior to 01/20/2026. B.Record review of a Resident Face Sheet revealed the facility admitted Resident 6 on 11/11/2025 with diagnosis right stage 2 pressure ulcer (a partial thickness skin loss appearing as a shallow pink or red moist open ulcer or rupture blister that is often painful), of the right buttock and stage 1 pressure ulcer (an early stage localized injury to intact skin that presents as redness that does not turn white when pressed) of the left buttock. Record review of the comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 11/17/2025 for Resident 1 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14 indicating the resident was cognitively intact. The MDS was coded to reflect the resident required substantial or maximal assistance with transfers, toilet use, and bed mobility, and was dependent on staff<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | assistance with eating. The resident had an indwelling foley catheter (a tube inserted into the bladder to drain the bladder of urine) and continent of bowel. Under the skin conditions portion of the MDS the resident was identified to be at risk and to have unhealed stage 1 and stage 2 pressure injuries. The resident had pressure reducing device to their chair and bed and was receiving pressure injury care and application of non-surgical dressings.Record review of Resident 6's Care Plan on 02/04/2026 revealed a problem of the resident had impaired skin integrity due to impaired mobility and had a pressure sore present on admission dated 11/12/2025. A goal was listed of the ulcers would heal without complications by the next care plan review dated 02/26/2026. Interventions listed were nursing to assess and record the condition of the residents skin surrounding the pressure ulcer weekly, to follow the sound care orders for treatments, to reposition the resident and off load every 2-3 hours, and a RoHo (pressure relieving cushion) to the residents wheel chair and recliner and a low air loss mattress to the residents bed all dated 11/12/2025. In an interview completed on 02/04/2026 at 1:35 PM with Resident 6, Resident 6 stated that they had a soar on their bottom and nursing staff provided treatment to the area daily.Record review of a facility supplied document titled admission Skin Assessment dated 11/11/2025 revealed documentation of a stage 2 pressure injury to the right buttock with measurements of 2.5 centimeters by 1.5 centimeters and a stage 1 pressure injury to the left buttock with measurements of 0.5 centimeters by 0.5 centimeters. Record review of facility supplied document titled Wound Management Detail Report revealed documentation of complete wound assessment of the residents right and left buttock dated 12/02/2025 and 12/16/2025. Record review or Resident 6's Progress Notes revealed the following documentation:-11/11/2025 the resident admitted to the facility with a stage 2 pressure ulcer and a stage 1 pressure ulcer to their right and left buttock.-11/17/2025 the resident was seen by wound care provider and received order for sitting position for only one hour to eat.-11/24/2025 the resident was seen by wound care provider and received order to continue with strict bed rest except for meals and must lie on sides when in bed.-12/08/2025 the resident was seen by wound care provider and received order for ok to take shower, may resume physical and occupational therapy, and ok to take the resident off bed rest and continue with treatment.-12/22/2025 The resident was seen by wound care provider with no new orders.-01/02/2026 the residents dressing was changed the wound was documented to be intact and dry with blanchable redness present. There were no measurements present in the documentation.-01/21/2026 the residents dressing was changed and the documentation stated that during the dressing change the prior day the resident's sacral area was noted to be intact. During the change of dressing this shift the residents were identified to have open areas to the left side of their buttock measuring 1.5 centimeters by 2 centimeters, and to the right side of their buttock measuring 2.5 centimeters by 2 centimeters. The residents wound care provider was notified of this with an appointment scheduled for 01/26/2026.-01/26/2026 the resident was seen by wound care provider with orders to continue with the dressing and barrier cream and to avoid scooting to stand and off loading of the pressure injury.Record review of a facility supplied document titled Clinic Visit Sheet dated 01/05/2026 revealed documentation that the residents pressure injuries had healed and to continue preventive measures.In an interview completed on 02/09/2026 at 10:00 AM with LPN-B, LPN-B states that the ADON completed weekly wound measurements and assessments. The LPN stated that when an area of skin alteration if first found or observed it should be measured assessed and the ADON who does the wound care is notified. The LPN confirmed that this should be entered as a progress note in the resident's health record.In an interview on 01/09/2026 at 10:48 AM with the facility ADON, the ADON confirmed that Resident 6 was admitted to the facility with pressure related skin injuries. The ADON stated that there was no routine documentation present for Resident 6's pressure related injury by facility staff from 11/11/2025 through 12/02/2025 as outlined in the facility policy. The ADON confirmed that the residents pressure injuries had resolved and then reopened. In an interview completed on 01/09/2026 at 12:30 PM with the facility Director of Nursing (DON), the DON confirmed that there were no routine documentation or measurements or<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | assessments for Resident 6's wounds prior to 12/02/2026. The DON confirmed there was no weekly summary of findings from skin assessments made by the ADON in Resident 6's medical record as outlined in the facility policy prior to 12/02/2025. C.Record review of a document titled Alternating pressure and low air loss mattress operators Manual dated 03/15/2016 revealed the pressure of the mattress is adjusted by choosing the patients corresponding weight setting using the weight setting dial.Record review of a Resident Face Sheet revealed the facility admitted Resident 6 on 11/11/2025 with diagnosis right stage 2 pressure ulcer (a partial thickness skin loss appearing as a shallow pink or red moist open ulcer or rupture blister that is often painful), of the right buttock and stage 1 pressure ulcer (an early stage localized injury to intact skin that presents as redness that does not turn white when pressed) of the left buttock. Record review of the comprehensive Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 11/17/2025 for Resident 1 revealed the resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14 indicating the resident was cognitively intact. The MDS was coded to reflect the resident required substantial or maximal assistance with transfers, toilet use, and bed mobility, and was dependent on staff assistance with eating. The resident had an indwelling foley catheter (a tube inserted into the bladder to drain the bladder of urine) and continent of bowel. Under the skin conditions portion of the MDS the resident was identified to be at risk and to have unhealed stage 1 and stage 2 pressure injuries. The resident had pressure reducing device to their chair and bed and was receiving pressure injury care and application of non-surgical dressings.Record review of Resident 6's Care Plan on 02/04/2026 revealed a problem of the resident had impaired skin integrity due to impaired mobility and had a pressure sore present on admission dated 11/12/2025. A goal was listed of the ulcers would heal without complications by the next care plan review dated 02/26/2026. Interventions listed were nursing to assess and record the condition of the residents skin surrounding the pressure ulcer weekly, to follow the sound care orders for treatments, to reposition the resident and off load every 2-3 hours, and a RoHo (pressure relieving cushion) to the residents wheel chair and recliner and a low air loss mattress to the residents bed all dated 11/12/2025. In an observation completed on 02/04/2026 at 1:35 PM Resident 6 was observed to be lying in their bed with the head of the bed elevated greater then 45 degrees in a supine (flat on back) position. The control box of the resident's low air loss mattress was observed to be sitting on the floor at the foot of the resident's bed. The pressure adjustment knob was observed to be in the firm position.In an observation completed on 02/05/2026 at 8:32 AM Resident 6 low air loss mattress control box was observed to be sitting on the floor at the foot of the resident's bed. The pressure adjustment knob was observed to be in the firm position.In an observation completed on 02/09/2026 at 9:45 AM Resident 6 low air loss mattress control box was observed to be sitting on the floor at the foot of the resident's bed. The pressure adjustment knob was observed to be in the firm position.In an interview completed on 02/09/2026 at 9:50 AM with Licensed Practical Nurse C (LPN-C) LPN-C stated that the air exchange mattresses are set per the resident's weight. The LPN stated they are not sure who monitors the control boxes to ensure that the setting is correct for the resident.In an interview completed on 02/09/2026 at 10:00 AM with the Maintenance Supervisor (MS), the MS stated that when a resident needs a low air loss mattress, they are notified by nursing staff. The MS stated that they install the mattress and adjust the settings as directed by the nursing staff or ADON. The MS was not aware of who monitored the control box ensuring the setting remained at the correct setting for the resident.In an interview completed on 02/09/2026 at 10:10 AM with the facility ADON, the ADON confirmed that the low loss air exchange mattresses are set by the resident's weight. In an observation completed on 02/09/2026 at 10:02 AM of Resident 6's control box of their low air loss mattress control box set in the firm position the ADON confirmed that this was not the correct setting for the resident. The ADON confirmed that there was not a procedure in place in the facility to ensure that the settings on the control boxes of the low air loss mattress remained at the correct setting for<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the resident. D.Record review of a facility policy titled Clean Dressing Change and dated 2023 revealed to cleanse the wound as ordered taking care not to contaminate other skin surfaces or other surfaced of the wound i.e. clean outward from the center of the wound.In an observation completed on 02/09/2026 at 9:30 of wound care being provided to Resident 6 by LPN-C the following was observed. LPN-C opened a small pink disposable plastic vial containing normal saline and a white and blue package containing a 4X4 white piece of gauze. With the resident in a standing position the LPN held the folded piece of gauze at the bottom of the cleft of the resident's buttock. The LPN used their other hand to squeeze the vial of normal saline onto the wounds covering the right and left sides of the resident's buttock and cleft allowing the fluid to drip/flow onto the piece of gauze. The LPN then folded the gauze in half and used the gauze to pat the residents wound multiple times. The LPN then folded the piece of gauze again in half and used it to continue to dab at the residents wound multiple times.In an interview completed on 02/09/2026 with LPN-C, LPN-C confirmed that the wound should have been cleansed using a circular motion from inside working to the outside of the wound and did not cleanse the wound in this manner.In an interview completed on 01/09/2026 at 12:30 PM with the facility Director of Nursing (DON), the DON confirmed that wounds should be cleansed in a circular motion working from inside to the outside of the wound and the LPN did not cleanse the wound correctly. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D)Based on observation, record review, and interview the facility failed to ensure a medication error rate of less than 5% with an observed medication error rate of 8% (25 medication administration observations and 2 errors). This affected 2 of 7 residents observed (Residents 28 and 53). The facility census was 45.Findings are: A. Record review of the facility policy titled Insulin Pen dated 2024 revealed that it is the policy of the facility to use insulin pens in order to improve the accuracy of dosing. Insulin pens contain multiple doses of insulin but are used for a single resident only. A new needle will be used for each injection. Always review physician orders prior to administering any medication. The procedure revealed that staff will gather supplies needed: correctly labeled insulin pen, alcohol preps, and sterile insulin pen needle. Perform hand hygiene. Put on gloves. Verify resident identification. Check the expiration date on the pen and discard if expired. Remove the pen cap from the insulin pen. Wipe the rubber seal with an alcohol pad. Screw the pen needle onto the insulin pen. Twist open and remove the outer cover from the pen needle. Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Set the insulin Dose: Turn the dose selector to the ordered dose. A click will be heard for each unit dialed. Check the dose a second time. Injecting the insulin: Cleanse the skin with an alcohol pad. Inject the needle straight at a 90-degree angle to the skin. Fully depress the plunger until the dosing numbers count back to zero. Keep the needle in the skin for up to 6-10 seconds while still pressing the plunger and then remove the needle from the skin. Record review of the Instructions for Use Humalog KwikPen (an insulin pen containing rapid-acting prescription insulin used to treat high blood sugar for residents with diabetes) dated 7/2023 revealed that priming the pen means removing the air from the needle and cartridge. You may get too much or too little insulin if you do not prime before each injection. The section titled giving the injection revealed the steps to insert the needle into the skin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 28 dated [DATE] revealed that Resident 28 admitted into the facility on [DATE]. Resident 28 had an active diagnosis of diabetes. Resident 28 received insulin injections on all 7 days of the assessment lookback period. Observation on [DATE] at 11:12 AM at the room of Resident 28 revealed that Licensed Practical Nurse-B (LPN-B) entered the resident room and performed hand sanitization. LPN-B placed a paper towel on the over bed table and organized supplies to check the resident's blood sugar. LPN-B wiped the pad of the left middle finger of Resident 28 with an alcohol prep pad. LPN-B punctured the pad of Resident 28's left middle finger and wiped the first drop of blood off with a cotton ball. LPN-B applied a drop of blood to the glucometer test strip and announced the blood sugar result of 242. LPN-B went to the medication cart located across from the front desk and reviewed the insulin orders for Resident 28. LPN-B revealed that Resident 28 has the routine order for 10 units of Humalog insulin (a rapid-acting prescription insulin used to treat high blood sugar for residents with diabetes) and also for Humalog insulin sliding scale (an insulin order that varies the dose of insulin based on the blood sugar level. The higher your blood sugar level the more insulin you take). LPN-B confirmed that Resident 28 is to receive 14 units of Humalog insulin for the blood sugar result of 242. LPN-B revealed that a total of 24 units of Humalog insulin is ordered to be given to Resident 28. LPN-B removed the Humalog insulin pen from the drawer of the medication cart. The Humalog insulin pen label had an open date of [DATE]. LPN-B removed the cap from the insulin pen and applied a needle to the pen. (LPN-B did not wipe the rubber seal on the top of the insulin pen with an alcohol prep pad prior to putting the needle on the pen). LPN-B dialed the dose selector on the insulin pen to 24 units. (LPN-B did not dial the selector to 2 units and prime the needle prior to<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285254 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mother Hull Home | 125 East 23rd Street<br>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 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | selecting the ordered dose of insulin as required). LPN-B took the pen into the room of Resident 28. LPN-B asked Resident 28 what area they would like the insulin injected in. Resident 28 wanted to use their left upper arm. LPN-B wiped an area on the left upper arm of Resident 28 with an alcohol prep pad. LPN-B injected the Humalog insulin into the upper left arm of Resident 28 and immediately removed the needle from the skin (LPN-B did not keep the needle in the skin for the 6-10 seconds as required) (a medication error). Record review of the medication administration record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) for Resident 28 dated [DATE] revealed the order for Humalog Insulin 10 units once a day. The administration of the 10 units of insulin on [DATE] was documented by LPN-B. The MAR revealed the order for the sliding scale Humalog Insulin for a blood sugar between 201 and 250 was to give 14 units. The administration of the 14 units of insulin on [DATE] was documented by LPN-B.Interview on [DATE] at 12:06 PM with LPN-B confirmed that LPN-B did not prime the insulin pen and was unaware of what priming the insulin pen was. LPN-B confirmed that LPN-B did not hold the needle in the skin for 6-10 seconds as required during administration.Interview on [DATE] at 12:39 PM with the facility Director of Nursing (DON) confirmed that staff are required to prime the insulin pen prior to selecting the ordered dose of insulin to ensure that the correct dose is administered. The DON confirmed that the insulin pen needle is required to be left in the skin for 6-10 seconds during administration to ensure proper administration of the ordered insulin dose. B.Record review of the MDS assessment for Resident 53 dated [DATE] revealed that Resident 53 admitted into the facility on [DATE]. Resident 53 had an active diagnosis of diabetes. Resident 53 received insulin injections on all 7 days of the assessment lookback period. Observation on [DATE] at 11:32 AM at the medication cart outside the room of Resident 53 revealed that Licensed Practical Nurse-C (LPN-C) reviewed the insulin order for Resident 53. LPN-C entered the blood sugar result of 388 into the medical record and revealed that Resident 53 is to receive 12 units of Humalog insulin per the sliding scale order. LPN-C removed the Humalog insulin pen from the medication cart. The insulin pen label showed the open expiration date of [DATE]. LPN-C removed the cap from the insulin pen and wiped the top seal of the pen with an alcohol pad. LPN-C attached a needle to the pen and dialed the selector to 2 units. LPN-C pressed the plunger while holding the pen with the needle upward. Insulin was observed dripping from the needle. LPN-C dialed the selector on the insulin pen to 12 units and took the pen into the room of Resident 53. LPN-C performed hand washing and put on gloves. LPN-C asked Resident 53 what site the resident wanted the insulin administered in. Resident 53 replied arm. LPN-C wiped the skin of the back of the right upper arm with an alcohol pad. LPN-C administered the insulin into the back of the right upper arm and pressed the plunger and immediately removed the needle from the skin. Clear liquid came out of the needle insertion site. (LPN-C did not keep the needle in the skin for the 6-10 seconds as required) (a medication error). Record review of the MAR for Resident 53 dated [DATE] revealed the order for Humalog Insulin sliding scale before meals and at bedtime. The order revealed Humalog insulin 12 units to be administered for a blood sugar between 351 and 400. The administration of the 12 units of insulin on [DATE] was documented by LPN-C.Interview on [DATE] at 3:22 PM with LPN-C confirmed that the insulin pen needle is to be left in the skin for 6-10 seconds during administration. LPN-C confirmed that LPN-C did not keep the needle in the skin for the required 6-10 seconds during insulin administration to Resident 53. Interview on [DATE] at 12:39 PM with the facility Director of Nursing (DON) confirmed that the insulin pen needle is required to be left in the skin for 6-10 seconds during administration to ensure proper administration of the ordered insulin dose. |

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| | 285254 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mother Hull Home | 125 East 23rd Street<br>Kearney, NE 68847 |

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|---|---|
| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.10(D)Based on observation, record review, and interview the facility failed to ensure that residents were free of significant medication errors for 2 of 7 residents observed (Residents 28 and 53). The facility census was 45.Findings are: A. Record review of the facility policy titled Insulin Pen dated 2024 revealed that it is the policy of the facility to use insulin pens in order to improve the accuracy of dosing. Insulin pens contain multiple doses of insulin but are used for a single resident only. A new needle will be used for each injection. Always review physician orders prior to administering any medication. The procedure revealed that staff will gather supplies needed: correctly labeled insulin pen, alcohol preps, and sterile insulin pen needle. Perform hand hygiene. Put on gloves. Verify resident identification. Check the expiration date on the pen and discard if expired. Remove the pen cap from the insulin pen. Wipe the rubber seal with an alcohol pad. Screw the pen needle onto the insulin pen. Twist open and remove the outer cover from the pen needle. Prime the insulin pen: Dial 2 units by turning the dose selector clockwise. With the needle pointing up, push the plunger and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Set the insulin Dose: Turn the dose selector to the ordered dose. A click will be heard for each unit dialed. Check the dose a second time. Injecting the insulin: Cleanse the skin with an alcohol pad. Inject the needle straight at a 90-degree angle to the skin. Fully depress the plunger until the dosing numbers count back to zero. Keep the needle in the skin for up to 6-10 seconds while still pressing the plunger and then remove the needle from the skin. Record review of the Instructions for Use Humalog KwikPen (an insulin pen containing rapid-acting prescription insulin used to treat high blood sugar for residents with diabetes) dated 7/2023 revealed that priming the pen means removing the air from the needle and cartridge. You may get too much or too little insulin if you do not prime before each injection. The section titled giving the injection revealed the steps to insert the needle into the skin. Push the dose knob all the way in. Continue to hold the dose knob in and slowly count to 5 before removing the needle. Record review of the manufacturer package insert for the Humalog Insulin pen dated 1/2026 revealed that Humalog is a rapid acting insulin. Hypoglycemia (low blood sugar) is the most common adverse reaction to insulin and can cause seizures, may be life-threatening, or cause death. The section titled Administration Instructions revealed that the dose of insulin is to be administered within fifteen minutes before a meal or immediately after a meal. Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 28 dated [DATE] revealed that Resident 28 admitted into the facility on [DATE]. Resident 28 had an active diagnosis of diabetes. Resident 28 received insulin injections on all 7 days of the assessment lookback period. The MDS revealed that Resident 28 had a Brief Interview for Mental Status (BIMS) (a brief screening tool that aids in detecting cognitive impairment) score of 15 indicating that Resident 28 is cognitively intact.Observation on [DATE] at 11:12 AM at the room of Resident 28 revealed that Licensed Practical Nurse-B (LPN-B) entered the resident room and performed hand sanitization. LPN-B placed a paper towel on the over bed table and organized supplies to check the resident's blood sugar. LPN-B wiped the pad of the left middle finger of Resident 28 with an alcohol prep pad. LPN-B punctured the pad of Resident 28's left middle finger and wiped the first drop of blood off with a cotton ball. LPN-B applied a drop of blood to the glucometer test strip and announced the blood sugar result of 242. LPN-B went to the medication cart located across from the front desk and reviewed the insulin orders for Resident 28. LPN-B revealed that Resident 28 has the routine order for 10 units of Humalog insulin (a rapid-acting prescription insulin used to treat high blood sugar for residents with diabetes) and also for Humalog insulin sliding scale (an insulin order that varies the dose of insulin based on the blood sugar level. The higher your blood sugar level the more insulin you take). LPN-B confirmed that Resident 28 is to receive 14 units of Humalog insulin for the blood sugar result of 242. LPN-B revealed<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285254 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mother Hull Home | 125 East 23rd Street<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | that a total of 24 units of Humalog insulin is ordered to be given to Resident 28. LPN-B removed the Humalog insulin pen from the drawer of the medication cart. The Humalog insulin pen label had an open date of [DATE]. LPN-B removed the cap from the insulin pen and applied a needle to the pen. (LPN-B did not wipe the rubber seal on the top of the insulin pen with an alcohol prep pad prior to putting the needle on the pen). LPN-B dialed the dose selector on the insulin pen to 24 units. (LPN-B did not dial the selector to 2 units and prime the needle prior to selecting the ordered dose of insulin as required). LPN-B took the pen into the room of Resident 28. LPN-B asked Resident 28 what area they would like the insulin injected in. Resident 28 wanted to use their left upper arm. LPN-B wiped an area on the left upper arm of Resident 28 with an alcohol prep pad. LPN-B injected the Humalog insulin into the upper left arm of Resident 28 and immediately removed the needle from the skin (LPN-B did not keep the needle in the skin for the 6-10 seconds as required) (a medication error). The time was 11:17:36 AM. LPN-B did not offer anything to eat or drink to Resident 28. LPN-B exited the room and went to the medication cart. Resident 28 remained seated in the wheelchair in the middle of the room. Resident 28 did not eat or drink anything. Nuse Aide-D (NA-D) entered the room of Resident 28 at 11:35 AM with the sit to stand mechanical lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own from a seated position). NA-D transferred Resident 28 from the wheelchair into the bathroom and then left the resident room. Resident 28 remained in the bathroom. Nurse Aide-E (NA-E) went into the room of Resident 28 at 11:46 AM. NA-E transferred Resident 28 from the bathroom into the wheelchair in the room. NA-E exited the resident room at 11:50 AM. Resident 28 remained seated in the wheelchair in the room. (Resident 28 had not had anything to eat or drink since the administration of the insulin). Resident 28 began to propel themself in the wheelchair and exited the room to go to the dining room. Resident 28 arrived at their table in the dining room at 11:55 AM. A glass of water, a glass of tea, and a small bowl of diced peaches with whipped cream sat on the table. Resident 28 picked up the salad bar menu from the table. Resident 28 did not drink or eat anything. Dietary Aide-F (DA-F) took a Styrofoam cup with lid and straw filled with Diet Dr. Pepper along with the open can with the remaining Diet Dr. Pepper to Resident 28. Resident 28 took a sip of the Diet Dr. Pepper at 11:59:46 AM. Resident 28 took the lid off of the diced peaches and took a bite of the peaches at 12:01:24 PM (this was 43 minutes after the Humalog insulin was administered to Resident 28). (The Humalog insulin was not administered within 15 minutes of a meal creating the risk of hypoglycemia). Interview on [DATE] at 12:01 PM with Resident 28 confirmed that staff do not give the resident anything to eat or drink after they administer the insulin. Resident 28 confirmed that Resident 28 had not had anything to eat or drink after the insulin was administered until now.Record review of the medication administration record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) for Resident 28 dated [DATE] revealed the order for Humalog Insulin 10 units once a day. The administration of the 10 units of insulin on [DATE] was documented by LPN-B. The MAR revealed the order for the sliding scale Humalog Insulin for a blood sugar between 201 and 250 was to give 14 units. The administration of the 14 units of insulin on [DATE] was documented by LPN-B.Interview on [DATE] at 12:06 PM with LPN-B confirmed that LPN-B did not prime the insulin pen and was unaware of what priming the insulin pen was. LPN-B confirmed that LPN-B did not hold the needle in the skin for 6-10 seconds as required during administration. LPN-B confirmed that LPN-B did not provide Resident 28 with anything to drink or eat after administering the insulin. Interview on [DATE] at 12:39 PM with the facility Director of Nursing (DON) confirmed that staff are required to prime the insulin pen prior to selecting the ordered dose of insulin to ensure that the correct dose is administered. The DON confirmed that the insulin pen needle is required to be left in the skin for 6-10 seconds during administration to ensure proper administration of the ordered insulin dose. The DON confirmed that Humalog insulin is a fast acting insulin and nurses are required to ensure that the resident receives nourishment within 15 minutes after administration of the insulin. B.Record review of the MDS assessment for Resident 53 dated [DATE] revealed that Resident 53 admitted into the facility on [DATE]. Resident 53 had an<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285254 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mother Hull Home | 125 East 23rd Street<br>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 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | active diagnosis of diabetes. Resident 53 received insulin injections on all 7 days of the assessment lookback period. The MDS revealed that Resident 53 had a BIMS score of 15 indicating that Resident 53 is cognitively intact.Observation on [DATE] at 11:32 AM at the medication cart outside the room of Resident 53 revealed that Licensed Practical Nurse-C (LPN-C) reviewed the insulin order for Resident 53. LPN-C entered the blood sugar result of 388 into the medical record and revealed that Resident 53 is to receive 12 units of Humalog insulin per the sliding scale order. LPN-C removed the Humalog insulin pen from the medication cart. The insulin pen label showed the open expiration date of [DATE]. LPN-C removed the cap from the insulin pen and wiped the top seal of the pen with an alcohol pad. LPN-C attached a needle to the pen and dialed the selector to 2 units. LPN-C pressed the plunger while holding the pen with the needle upward. Insulin was observed dripping from the needle. LPN-C dialed the selector on the insulin pen to 12 units and took the pen into the room of Resident 53. LPN-C performed hand washing and put on gloves. Resident 53 was in the bed in the room. LPN-C asked Resident 53 what site the resident wanted the insulin administered in. Resident 53 replied arm. LPN-C wiped the skin of the back of the right upper arm with an alcohol pad. LPN-C administered the insulin into the back of the right upper arm and pressed the plunger and immediately removed the needle from the skin. Clear liquid came out of the needle insertion site. (LPN-C did not keep the needle in the skin for the 6-10 seconds as required) (a medication error). The time was 11:35:05 AM. LPN-C did not offer anything to eat or drink to Resident 53. LPN-C exited the resident room. No over bed table or any drink or snack were in reach of the resident. The unidentified Physical Therapist (PT) entered the room of Resident 53 at 11:39 AM. The unidentified PT told Resident 53 that they were there to work with Resident 53. PT provided exercise to the resident as Resident 53 remained in the bed. PT instructed and assisted Resident 53 to perform active exercises of the legs. PT recruited Nurse Aide-G (NA-G) to assist in transferring Resident 53 up in the bed at 11:53 AM. PT and NA-G transferred Resident 53 up in the bed and NA-G exited the resident room at 11:55 AM. PT continued with active exercises with the resident. PT exited the resident room after ensuring the resident call light was activated at 12:00 PM. Resident 53 had not received any nourishment since the insulin administration at 11:35:05 AM. NA-G and Nurse Aide-H (NA-H) entered the room of Resident 53 at 12:03 PM with the mechanical total body lift (a mechanical assistive device used to transfer a resident with difficulty standing up on their own). Resident 53 was transferred from the bed and into the wheelchair. NA-H transported Resident 53 out of the resident room to a table in the dining room at 12:13 PM. A container of pudding sat on the table in front of the resident. Resident 53 picked up the pudding cup and removed the sealed top. Resident 53 licked the removed top at 12:16:31 PM. Resident 53 picked up a spoon and began to take bites of pudding (this was 41 minutes after the Humalog insulin was administered to Resident 53). (The Humalog insulin was not administered within 15 minutes of a meal creating the risk of hypoglycemia). Record review of the MAR for Resident 53 dated [DATE] revealed the order for Humalog Insulin sliding scale before meals and at bedtime. The order revealed Humalog insulin 12 units to be administered for a blood sugar between 351 and 400. The administration of the 12 units of insulin on [DATE] was documented by LPN-C.Interview on [DATE] at 3:22 PM with LPN-C confirmed that the insulin pen needle is to be left in the skin for 6-10 seconds during administration. LPN-C confirmed that LPN-C did not keep the needle in the skin for the required 6-10 seconds during insulin administration to Resident 53. LPN-C confirmed that LPN-C did not provide nourishment to Resident 53 within 15 minutes after insulin administration. Interview on [DATE] at 12:39 PM with the facility Director of Nursing (DON) confirmed that the insulin pen needle is required to be left in the skin for 6-10 seconds during administration to ensure proper administration of the ordered insulin dose. The DON confirmed that Humalog insulin is a fast acting insulin and nurses are required to ensure that the resident receives nourishment within 15 minutes after administration of the insulin. |

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| Mother Hull Home | 125 East 23rd Street<br>Kearney, NE 68847 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.18(B)Licensure Reference Number 175 NAC 1-005.06(F)Based on observation, record review, and interview the facility failed to ensure that staff disinfected medication administration equipment as required for 1 of 2 residents observed (Resident 28); and the facility failed to ensure that hand hygiene was performed between glove changes during wound care for 1 resident (Resident 6) to prevent the potential for cross contamination. The facility census was 45.Findings are: A.<br><br>Record review of the facility policy titled Insulin Pen dated 2024 revealed that it is the policy of the facility to use insulin pens in order to improve the accuracy of dosing. A new needle will be used for each injection. Always review physician orders prior to administering any medication. The procedure revealed that staff will gather supplies needed: correctly labeled insulin pen, alcohol preps, and sterile insulin pen needle. Perform hand hygiene. Put on gloves. Verify resident identification. Check the expiration date on the pen and discard if expired. Remove the pen cap from the insulin pen. Wipe the rubber seal with an alcohol pad. Screw the pen needle onto the insulin pen.<br><br>Record review of the Instructions for Use Humalog KwikPen (an insulin pen containing rapid-acting prescription insulin used to treat high blood sugar for residents with diabetes) dated 7/2023 section titled Preparing your Pen revealed the instruction to pull the pen cap straight off. Wipe the rubber seal with an alcohol swab. Select a new needle and push the capped needle straight onto the pen and twist the needle until it is tight.<br><br>Record review of the Minimum Data Set (MDS) (a mandatory comprehensive assessment tool used for care planning) for Resident 28 dated [DATE] revealed that Resident 28 admitted into the facility on [DATE]. Resident 28 had an active diagnosis of diabetes. Resident 28 received insulin injections on all 7 days of the assessment lookback period.<br><br>Observation on [DATE] at 11:12 AM at the room of Resident 28 revealed that Licensed Practical Nurse-B (LPN-B) entered the resident room and performed hand sanitization. LPN-B placed a paper towel on the over bed table and organized supplies to check the resident's blood sugar. LPN-B wiped the pad of the left middle finger of Resident 28 with an alcohol prep pad. LPN-B punctured the pad of Resident 28's left middle finger with the lancet (a small sterile blade used to obtain a small amount of blood for testing) and wiped the first drop of blood off with a cotton ball. LPN-B applied a drop of blood to the glucometer test strip and announced the blood sugar result of 242. LPN-B disposed of the lancet and test strip. LPN-B stored the glucometer and removed the gloves. LPN-B performed hand washing for a total of 9 seconds. LPN-B went to the medication cart located across from the front desk and reviewed the insulin orders for Resident 28. LPN-B revealed that Resident 28 has the routine order for 10 units of Humalog insulin (a rapid-acting prescription insulin used to treat high blood sugar for residents with diabetes) and also for Humalog insulin sliding scale (an insulin order that varies the dose of insulin based on the blood sugar level. The higher your blood sugar level the more insulin you take). LPN-B confirmed that Resident 28 is to receive 14 units of Humalog insulin for the blood sugar result of 242. LPN-B revealed that a total of 24 units of Humalog insulin is ordered to be given to Resident 28. LPN-B removed the Humalog insulin pen from the drawer of the medication cart. The Humalog insulin pen label had an open date of [DATE]. LPN-B removed the cap from the insulin pen and applied a needle to the pen. (LPN-B did not wipe the rubber seal on the top of the insulin pen with an alcohol prep pad to disinfect it as required prior to putting the needle on the pen). LPN-B dialed the dose selector on the insulin pen to 24 units. (LPN-B did not dial the selector to 2 units and prime the<br>(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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | needle prior to selecting the ordered dose of insulin as required). LPN-B took the pen into the room of Resident 28. LPN-B asked Resident 28 what area they would like the insulin injected in. Resident 28 wanted to use their left upper arm. LPN-B wiped an area on the left upper arm of Resident 28 with an alcohol prep pad. LPN-B injected the Humalog insulin into the upper left arm of Resident 28 and immediately removed the needle from the skin.<br><br>Record review of the medication administration record (MAR) (a legal record of the medications administered to a patient at a facility by a health care professional) for Resident 28 dated [DATE] revealed the order for Humalog Insulin 10 units once a day. The administration of the 10 units of insulin on [DATE] was documented by LPN-B. The MAR revealed the order for the sliding scale Humalog Insulin for a blood sugar between 201 and 250 was to give 14 units. The administration of the 14 units of insulin on [DATE] was documented by LPN-B.<br><br>Interview on [DATE] at 12:06 PM with LPN-B confirmed that LPN-B did not wipe the top of the insulin pen to disinfect it prior to applying the needle.<br><br>Interview on [DATE] at 12:39 PM with the facility Director of Nursing (DON) confirmed that staff are expected to disinfect the top of the insulin pen before putting on the needle.<br><br>B.<br><br>Record review of a facility policy titled Hand Hygiene and dated 2021 revealed the use of gloves does not replace hand hygiene. If the task requires gloves, perform hand hygiene prior to donning gloves and immediately after removing gloves.<br><br>Record review of a facility policy titled Clean Dressing Change and dated 2023 revealed 10. Remove gloves and discard into appropriate receptacle. 11. Perform hand hygiene and put on clean gloves 14. perform hand hygiene and put on clean gloves 17. discard disposable items and gloves into appropriate trash receptacle and perform hand hygiene.<br><br>In an interview completed on [DATE] at 1:35 PM with Resident 6, Resident 6 stated that they had a soar on their bottom and nursing staff provided treatment to the area daily.<br><br>Record review of a Resident Face Sheet revealed the facility admitted Resident 6 on [DATE] with diagnosis right stage 2 pressure ulcer (a partial thickness skin loss appearing as a shallow pink or red moist open ulcer or rupture blister that is often painful), of the right buttock and stage 1 pressure ulcer (an early stage localized injury to intact skin that presents as redness that does not turn white when pressed) of the left buttock.<br><br>Record review of Resident 6's Physician Orders revealed the resident had order stating mepilex dressing on buttocks with directions to change daily and apply barrier cream before the dressing.<br><br>In an observation completed on [DATE] at 9:30 AM of wound care being provided to Resident 6 by Licensed Practical Nurse C (LPN-C) the following was observed. With gloved hands the LPN removed the old dressing covering the resident's buttock. The LPN then removed their gloves from both of their hands and placed new gloves onto their hands without performing hand hygiene. With gloved hands the LPN used normal saline and a piece of folded gauze to clean the residents wound. The LPN removed their gloves from both of their hands and placed new gloves onto their hands without performing hand hygiene. The LPN then squeezed out a cherry sized amount of a white cream from a<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 285254 | A. Building<br>B. Wing | 02/09/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mother Hull Home | 125 East 23rd Street<br>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.

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | tube onto their finder and using the gloved finger applied the cream to the wound on the resident's buttock. The LPN removed their gloves from both of their hands and placed new gloves onto their hands without performing hand hygiene. The LPN then removed the backing from a bordered foam dressing and placed the dressing over the cream covered wound on the resident's buttock. The LPN removed their gloves from both of their hands and placed new gloves onto their hands without performing hand hygiene. The LPN then assisted the residents to pull up their pants and sit back in their chair. The LPN then removed their gloves an went into the resident's bathroom and completed hand hygiene using soap and water.<br><br>In an interview completed on [DATE] with LPN-C, LPN-C confirmed that hand hygiene should be performed between each glove change and they did not do this.<br><br>In an interview completed on [DATE] at 12:30 PM with the facility Director of Nursing (DON), the DON confirmed that hand hygiene should be performed between each glove change and LPN-C did not do this. |