STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285256	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimball County Manor	810 East 7th Street Kimball, NE 69145

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 49263 Based on record review and interviews, the facility failed to ensure 1 (Resident 39) of 3 sampled residents' advance directive was added to their electronic health record. The facility census was 41. The Findings Are: A record review of Resident 39's paper medical chart, located in a room next to the nurse's station, revealed the resident had an advance directive indicating they did not want resuscitation (DNR). A record review of Resident 39's Electronic Health Record (EHR) revealed the statement no advanced directive on file for this resident. An interview on 5/2/2024 at 10:40 AM with Nurse Aide (NA)-E confirmed the staff would look at the resident's MAR (medication administration record), which was located in the EHR, to find out whether the resident was a DNR. An interview on 5/2/2024 at 10:41 AM with LPN-C confirmed they would look in the resident's EHR first to find the resident's code status (whether or not they were a DNR). An interview on 5/2/2024 at 11:10 AM with the Assistant Director of Nursing (ADON) confirmed Resident 39's advance directive was not in the resident's EHR. An interview on 5/2/2024 at 11:14 AM with Medical Records (MR)-F confirmed there was no advanced directive information in Resident 39's EHR. A record review of the facility policy Patient Self Determination Act (Advance Directive), with a review date of 2/2/24 revealed that if a resident had an advance directive, it would be documented, and a copy would be placed in the resident's medical record chart.

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Kimball County Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 810 East 7th Street Kimball, NE 69145	

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49766 Licensure Reference 175 NAC 12-006.09D7 Based on observations, interviews and record reviews, the facility failed to ensure the use of two-persons while utilizing a Hoyer lift for 1(Resident 8) and failed to ensure the oxygen concentrator was turned off when not in use for 1(Resident 35) of 5 sampled residents . The facility census was 41. Findings are: A. Record review of a Face Sheet indicated the facility admitted Resident 8 on 1/18/2019 with diagnoses of Dementia, Type 2 Diabetes Mellitus, Chronic Kidney Disease, difficulty in walking, and lack of coordination. A record review quarterly Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 3/21/2024, revealed Resident 8 had severe cognitive impairment. Further review of Resident 8's MDS dated [DATE] revealed Resident 8 was dependent for all cares and transfers. A record review of Resident 8's Care Plan revealed Resident 8 required assist of 2 for bed mobility, dressing, incontinence care and to use a Hoyer lift (type of mechanical lift) as needed. An observation on 5/2/2024 at 9:13 AM revealed Nurse Aide (NA)-A had placed Resident 8 in a Hoyer sling that had been connected to the Hoyer machine. NA-A then transferred Resident 8 from the wheelchair, across the room, to the bed and did not have a second staff member assisting with Resident 8's transfer. An interview on 5/2/2024 at 9:16 AM was conducted with NA-A. During the interview NA-A reported frequently using the Hoyer lift without a second person. A follow up interview was conducted on 5/2/2024 at 9:25 with NA-A. During the interview NA-A reported being aware of the requirement to utilize two people with the Hoyer lift. NA-A further revealed not being trained to run the Hoyer lift alone. An interview on 5/2/2024 at 12:20 PM with the Assistant Director of Nursing (ADON) revealed the expectation is for staff to always use a two-person assist with the Hoyer lift. A record review of a facility policy Using a Portable Lifting Machine (Sling), with a last reviewed date of 1/20/2024, revealed the Hoyer lift requires two nursing assistants to run. 49263 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B. A record review of website www.inogen.com revealed that oxygen itself is not a flammable gas, but it does support combustion. This means that fires ignite and burn more easily, and hotter, in an oxygen-rich environment. In order to maintain a safe environment while using supplemental oxygen, it is important to adhere to safe practices. The website also listed a safe oxygen storage guideline of Turn off your oxygen when you're not using it. Don't set the cannula or mask on the bed or a chair if the oxygen is turned on. An observation on 5/1/2024 at 8:10 AM revealed Resident 35 was not in their room. Their oxygen concentrator was turned on and the oxygen tubing was laying across Resident 35's bed sheets. An interview on 5/1/2024 at 8:13 AM with Licensed Practical Nurse (LPN)-I confirmed the oxygen concentrator was turned on and the tubing was laying on the bed and that this was a fire hazard. An observation on 5/2/2024 at 11:19 AM revealed Resident 35 was not in their room. Their oxygen concentrator was turned on at 4 liters and the oxygen tubing was laying on top of the bed sheets on the bed. An interview on 5/2/24 at 11:22 AM with Medication Aide (MA)-J confirmed they entered Resident 35's room at that time and turned off the oxygen concentrator and put the oxygen tubing into the bag attached to the concentrator.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49263 Licensure Reference 175 NAC 12-006.09D6 Based on observation, record review, and interview the facility failed to ensure oxygen was administered per the physician's orders for 2 (Residents 13 and 35) of 3 sampled residents. The facility census was 41. The findings are: A. A record review of the facility policy Oxygen Administration with review date of 2/20/24 revealed oxygen would be administered to residents as ordered by the physician. A record review of Resident 13's Care Plan revealed the resident was at risk for respiratory distress/failure related to COPD (Chronic Obstructive Pulmonary Disease) and that they were to have oxygen via nasal cannula per provider orders. A record review of Resident 13's physician's orders revealed an order for continuous O2 (oxygen) 1-2 Liters Per Minute (LPM) to keep saturations above 90%. The order was to be documented on twice a day indicating the oxygen flow rate. A record review of Resident 13's vital signs documentation revealed the following: -4/25/2024 at 4:17 PM Oxygen Saturation: 97%, Oxygen Use Liter Flow: 3. -4/22/2024 at 10:20 AM Oxygen Saturation: 96%, Oxygen Use Liter Flow: 3. -4/15/2024 at 5:58 AM Oxygen Saturation: 99%, Oxygen Use Liter Flow: 3. -4/11/2024 at 3:20 PM Oxygen Saturation: 98%, Oxygen Use Liter Flow: 3. -4/8/2024 at 8:57 AM Oxygen Saturation: 97%, Oxygen Use Liter Flow: 3. An observation on 5/2/24 at 2:20 PM revealed Resident 13 sitting upright in a recliner in their room. They were wearing their oxygen nasal cannula which was connected to the oxygen concentrator. The oxygen concentrator was sent at 2.5 LPM. B. A record review of Resident 35's Minimum Data Set (MDS), a federally mandated comprehensive assessment tool used for care planning, dated 3/7/24 revealed in Section O that the resident did utilize oxygen during the assessment period and in Section I that the resident had a primary medical condition of Acute respiratory failure with hypoxia. A record review of Resident 35's physician's orders revealed an order for oxygen at 3 LPM via nasal cannula continuous. The order was to be documented on twice a day indicating the oxygen flow rate. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of Resident 35's medication administration record revealed documentation that Resident 35's oxygen was set at 2 LPM every shift from 4/2/2024 through 5/2/2024. The resident's order on the medication administration record revealed the oxygen should have been set at 3 LPM. An observation on 5/2/24 at 11:44 AM revealed Resident 35 them sitting in a chair at a table in the dining room with their walker beside them and a small oxygen tank sitting in the basket of the walker. Resident 35 had the nasal cannula in their nose and the tubing was attached to the regulator on the oxygen tank in their walker. The regulator of the oxygen tank was set to the OFF position. An interview on 5/2/24 at 11:50 AM with the Assistant Director of Nursing (ADON) confirmed Resident 35's oxygen tank was set to the OFF position and should have been turned on per the physician's order. An observation on 5/2/24 at 11:50 AM revealed the ADON turned Resident 35's oxygen tank regulator on and set it to 2 LPM.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Based on interviews and record review, the facility failed to obtain an end date or obtain rationale for the continued use of antibiotics for Urinary Tract Infections (UTIs) for Resident 8 and 28 and for history of eye infections for Resident 39. This affected 3 (Resident 8, 28, and 39) of 3 sampled residents. The facility census was 41. Findings are: A record review of Center for Disease Control (CDC) document The Core Elements of Antibiotic Stewardship for Nursing Homes APPENDIX A: Policy and Practice Actions to Improve Antibiotic Use revealed Surveys of antibiotic use have shown that UTI prophylaxis accounts for a significant proportion of antibiotic prescriptions. Very few studies support antibiotic use for UTI prophylaxis, especially in older adults, and many studies have shown this antibiotic exposure increases risk of side effects and resistant organisms. Therefore, efforts to educate providers on the potential harm of antibiotics for UTI prophylaxis could reduce unnecessary antibiotic exposure and improve resident outcomes. A. A record review of a Face Sheet indicated the facility admitted Resident 8 on 1/18/2019 with diagnoses of Dementia, Type 2 Diabetes Mellitus, Chronic Kidney Disease, long term (current) use of antibiotics, overactive bladder, and acute kidney failure. A record review quarterly Minimum Data Set (MDS, a standardized assessment tool that measures health status in nursing home residents), with an Assessment Reference Date of 3/21/2024, revealed Resident 8 had severe cognitive impairment. A record review of Resident 8's Orders revealed Resident 8 was taking Bactrim since 10/8/2023 for a diagnosis of long term (current) use of antibiotics and there was no stop date for the order. An interview on 5/6/2024 at 10:30 AM revealed the Assistant Director of Nursing (ADON) was aware of the CDC's current recommendations regarding prophylactic antibiotic use and confirmed Resident 8 was on an antibiotic for prophylactic UTI use indefinitely. B. A record review of Resident 28's care plan revealed the resident had a history of septic shock, urinary tract infection (UTI), E. Coli infection, benign prostatic hypertrophy (BPH) with urinary obstruction, traumatic hematuria, and a penile implant. The care plan also revealed interventions to administer antibiotics as ordered by the provider and evaluate/record/report their effectiveness/adverse side effects, to encourage prompt and complete bladder emptying, to keep the resident's perineal area clean and dry, and to report signs of UTI. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 28's event report Infection Control-Infection Tracker revealed an infection onset date of 1/5/24 and an infection resolved date of 2/23/24, and an infection type of UTI. The report revealed that on 1/4/24 the bath aide had reported the resident had blood spots in their brief and that they resident denied pain or burning with urination. On 1/7/24, the resident reported they had trouble starting to pee. On 1/10/24, the resident reported feeling full in their abdomen, and the staff noted that the resident had not had a bowel movement in 3 days. On 2/19/24, staff observed a long and string-like blood clot specimen in resident's toilet, but resident's urine was clear of visible blood upon later urination that day. There was no other documentation in the event report regarding the resident having any symptoms of a urinary tract infection. The report also revealed the resident had their temperature checked routinely between 1/5/24 and 2/14/24 and they never had a fever. The report revealed the resident had a urinalysis on 11/30/23 and the result was positive UA. A record review of Resident 28's physician's orders revealed an order to administer cephalexin (an antibiotic) 500 milligrams (MG) four times a day from 1/5/24 through 1/11/24. A record review of Resident 28's physician's orders revealed an order to obtain a post antibiotic urinalysis on 1/20/24. A record review of Resident 28's scanned documents revealed a urinalysis was obtained on 1/21/24, with a final culture report dated 1/24/24 which revealed a result of greater than 100,000 cfu/ml of mixed flora, more than 3 organisms. A record review of Resident 28's physician's orders revealed an order to administer ceftriaxone (an antibiotic) 1 gram by injection once daily from 2/8/24 through 2/10/24. A record review of Resident 28's physician's orders revealed an order to obtain a follow up urinalysis on 2/21/24. No evidence of this urinalysis being obtained was found in the resident's chart. A record review of Resident 28's physician's orders revealed an order to obtain a follow up urinalysis with culture and sensitivity if indicated, post antibiotic on 2/29/24. No evidence of this urinalysis being obtained was found in the resident's chart. A record review of Resident 28's physician's orders revealed an order to obtain a urinalysis and a urine protein creatinine ratio (UPCR) as well as blood tests (complete blood count, renal panel, and parathyroid hormone) on 3/26/24. A record review of Resident 28's scanned documents revealed a urinalysis was obtained on 3/26/24, with a final culture report dated 3/29/24 with no bacterial growth. A record review of Resident 28's physician's orders revealed an order to administer Macrodantin (an antibiotic) 50 MG twice a day from 2/7/23 through 10/6/23. A record review of Resident 28's physician's orders revealed an order to administer Macrodantin (an antibiotic) 50 MG twice a day beginning on 10/6/23. The resident was still taking this medication on 5/7/24 and there was no indication or diagnosis listed on the order. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review of Resident 28's Progress Note dated 4/29/2024 at 7:00 PM revealed the resident continued to take a prophylactic antibiotic for a chronic UTI with no adverse effects noted and that the resident denied having any pain with urination. A record review conducted on 5/6/24 of Resident 28's Progress Notes revealed no documentation regarding resident's antibiotic use or urinary symptoms after 4/29/24. A record review of the website asap.nebraskamed.com revealed the Revised McGeer Criteria for Infection Surveillance Checklist which stated that for a voided urine sample, there was to be at least 100,000 cfu/ml of no more than two species of organisms when determining if a person had a urinary tract infection. A record review of the website pubmed.ncbi.nlm.gov revealed in an article titled The significance of urine culture with mixed flora that urine cultures that contain more than one organism are usually considered contaminated. C. A record review of Resident 39's face sheet revealed the resident was admitted to the facility on [DATE] with an admission diagnosis of periorbital cellulitis. A record review of Resident 39's Progress Note dated 2/13/24 revealed the resident had previously been hospitalized for periorbital cellulitis and congestive heart failure (CHF) exacerbation and had returned to the facility on this date. The resident had an order to start Doxycycline twice a day for ten days and to monitor the left side of the resident's face, near the lacrimal gland, for worsening cellulitis. A record review of Resident 39's physician's orders revealed an order dated 2/13/24 for Doxycycline (an antibiotic) 100 MG twice a day for ten days for irritated/inflamed eyes. A record review of Resident 39's Progress Note dated 2/23/24 revealed the resident continued to take an antibiotic for periorbital cellulitis and that the resident's eye had drainage and redness. The progress note also stated that a new order had been received to start Doxycycline for 30 days and to follow up with a doctor for a surgical procedure of the lacrimal duct. A record review of Resident 39's physician's orders revealed an order for Doxycycline 100 MG once daily at 7:00 PM for irritated/inflamed eyes. The order was in place from 2/24/24 to 3/25/24. A record review of Resident 39's Progress Note dated 3/27/24 revealed the resident seen a doctor and had an order to continue the daily Doxycycline 100 MG indefinitely. A record review of Resident 39's physician's orders revealed an order for Doxycycline 100 MG once daily at 7:30 PM for irritated/inflamed eyes with a start date of 3/27/24 and no end date. A record review of Resident 39's event report labeled Respiratory/EENT Events- Irritated/Inflamed Eye revealed the resident's eye infection was documented as resolved on 3/27/24 and that the antibiotic was continued as prophylactic indefinitely. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review conducted on 5/6/24 of Resident 39's Progress Notes revealed there had been no recent documentation regarding the resident's antibiotic use, adverse reactions, or the status of the resident's eye. A record review conducted on 5/6/24 of Resident 39's current orders revealed no evidence of an order to monitor the condition of the resident's eye or the antibiotic use. 49766

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 49766 Licensure Reference 175 NAC 12-006.10D Based on observations, interviews, and record reviews, the facility failed to ensure the medication error rate was less than 5% for 4 (Residents 5, 29, 32 and 38) of 8 sampled residents. Observations of 27 medication administered revealed 4 errors resulting in an error rate of 14.81%. The facility census was 41. Findings are: A record review of facility policy Medication Administration with a last revised date of 2/23/2010 revealed the following: - Medications are matched to the Medication Administration Record to check the correct resident, medication, dose, time, route, and documentation. -Medications will be passed in a timely manner, within the time frame of 60 minutes prior and 60 minutes after the prescribed time frame. A record review of Resident 29's Medication Administration Record revealed an order for levothyroxine with an administration time of 6:00 AM. An observation on 5/6/2024 at 7:13 AM revealed LPN-C had administered Resident 29's levothyroxine. A record review of Resident 38's Medication Administration Record revealed an order for gabapentin with an administration time of 6:00 AM. An observation on 5/6/2024 at 7:27 AM revealed LPN-C had administered Resident 38's levothyroxine. An interview on 5/6/2024 at 7:30 AM revealed LPN-C was aware of policy to administer one hour before and one hour after but admitted to running just a little behind. A record review of Resident 32's Medication Administration Record revealed an order for Tamsulosin with special instructions to take 30 minutes after morning meal. An observation on 5/6/2024 at 7:08 AM revealed Resident 32 had been sitting in the dining room awaiting breakfast. Licensed Practical Nurse (LPN) - C administered Resident 32's tamsulosin at this time. An interview on 5/6/2024 at 8:45 AM with LPN-C confirmed Resident 32's tamsulosin was given before breakfast despite the special instructions to give 30 minutes after breakfast. A record review of Resident 5's Medication Administration Record revealed an order for Miralax with special instructions to mix with 8 ounces of fluid. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 5/6/2024 at 7:22 AM revealed LPN-C had mixed MedPass liquid with the Miralax and then administered to Resident 5. An interview on 5/6/2024 at 7:24 AM with LPN-C confirmed the Miralax was mixed with only 4 ounces of Medpass liquid.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49766 Licensure Reference 175 NAC 12-006.11E Based on observations, interviews, and record reviews, the facility kitchen staff failed to utilize handwashing and gloving techniques to prevent the potential for cross contamination during meal preparation. This had the potential to affect all 41 residents who ate from the kitchen. The facility census was 41. Findings are: A record review of a facility policy Personal Sanitation for Dietary Employees with a last revised date of 11/2023 revealed hands should washed frequently including before starting work, after touching anything contaminated, before putting on gloves, after the removal of gloves, and upon entrance to the kitchen. A record review of a facility policy Wearing Protective/Disposable Gloves by Dietary Employees with a last revised date of 11/2023 revealed to change gloves as necessary to maintain cleanliness. An observation on 5/6/2024 at 2:47 PM revealed Dietary Staff (DS)-B had entered the kitchen to begin food preparation and did not complete hand hygiene upon entrance to the kitchen, obtained a box of buttermilk biscuit mix, opened it, and poured it into a bowl. An observation on 5/6/2024 at 2:49 PM revealed DS-B apply gloves without the benefit of completing hand hygiene prior and touched a permanent marker to date a opened milk with the gloved hand. DS-B opened a drawer with a gloved hand to obtain a mixing spoon and began to mix the milk and biscuit mixture together. Further observations revealed DS-B's gloved hand came into contact with the mixture. An observation on 5/6/2024 at 2:55 PM revealed DS-B change gloves and without the benefit of completing hand hygiene prior to donning the new pair of gloves. DS-B opened the door to the refrigerator to put milk away, opened the door to the walk-in-refrigerator to put cheese away and touched both handles with a gloved hand. DS-B opened a drawer with the same soiled gloves to obtain a scoop. DS-B began to scoop out the mixture of biscuit dough onto a pan touched one of the scoops of biscuit mixture to shape it with the soiled gloves. An interview on 5/6/2024 at 3:00 PM with DS-B revealed DS-B was aware of the need to wash hands upon entrance to the kitchen and when changing gloves. DS-B was also aware of the need to change gloves when switching tasks or when dirty. DS-B confirmed DS-B did not follow these practices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49263 Licensure Reference 175 NAC 12-006.17D. Based on observations, record review and interviews, the facility failed to implement hand hygiene during the distribution of resident laundry and during medication administration. This had the potential to affect all residents. The facility census was 41. The Findings Are: A. An observation on 5/6/2024 from 7:23 AM through 7:35 AM revealed Laundry Aide (LA)-G distributing personal laundry to resident rooms. LA-G pushed a rolling cart to room [ROOM NUMBER], took folded laundry from the basket section of the cart and knocked on the door of room [ROOM NUMBER]. The resident told LA-G to come back later, so LA-G took the laundry back to the cart. LA-G then pushed the cart up the hallway and then removed hanging shirts from the cart. LA-G knocked on the door of room [ROOM NUMBER], entered the room, hung up the shirts in the closet and removed an empty hanger from the closet and hung the hanger on the rolling cart. LA-G then pushed the laundry cart to the 400 hallway and stopped outside room [ROOM NUMBER], removing shirts from the cart. LA-G knocked on room [ROOM NUMBER]'s door, opened the door, hung the shirts in the resident's closet, turned off the room light, and closed the door. LA-G took additional clothing from the cart, knocked on the door to room [ROOM NUMBER], entered the room, hung the clothing in the closet and removed empty hangers, and placed the empty hangers on the rolling cart. LA-G then pushed the rolling cart further down the hall, took hanging clothing from the cart and knocked on the door to room [ROOM NUMBER]. LA-G opened the door to room [ROOM NUMBER], hung the clothing in the closet, then closed the room door as they exited. LA-G then took the cart back to the 200 hallway and returned to room [ROOM NUMBER]. LA-G obtained folded clothing from the basket of their cart, entered room [ROOM NUMBER], put the clothing inside a dresser drawer, and closed the door to the room as they exited. LA-G pushed the rolling cart back to room [ROOM NUMBER], obtained laundry from the basket, knocked on the door, opened a dresser drawer and put the laundry in, then closed the dresser drawer and the room door. LA-G then took laundry from the bottom of their cart, entered room [ROOM NUMBER], and placed laundry into two dresser drawers. LA-G closed the drawers and turned off the light to the room. LA-G pushed the rolling cart to the laundry room and then began folding laundry that was in a bin near the dryer. LA-G did not perform hand hygiene at any time during this observation. An interview on 5/6/2024 at 7:35 AM with LA-G confirmed they did not perform hand hygiene at any time during the distribution of resident laundry to the resident rooms. LA-G revealed they had been educated to perform hand hygiene when the facility had COVID-19 cases but that had not been told to perform hand hygiene since then. An interview on 5/6/2024 at 8:02 AM the Laundry Supervisor (LS)-H revealed the laundry staff were expected to perform hand hygiene after each resident room while distributing laundry. A record review of facility policy Handwashing/Hand Hygiene with last revised date of 2/27/23 revealed the staff should perform hand hygiene after handling contaminated equipment and after contact with objects in the immediate vicinity of the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285256	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER Kimball County Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 810 East 7th Street Kimball, NE 69145	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	49766 B. An observation on 5/6/2024 at 7:10 AM revealed Licensed Practical Nurse (LPN)-C had removed their gloves after completing a gel treatment to a resident. LPN-C then completed hand hygiene with soap and water for 14 seconds. An observation on 5/6/2024 at 7:08 AM revealed LPN-C completed a medication pass for Resident 32. LPN-C did not perform hand hygiene prior to beginning a medication pass for Resident 29. An observation on 5/6/2024 at 7:15 AM revealed LPN-C had prepared medications to administer to Resident 40. LPN-C had been walking toward Resident 40 when LPN-C greeted Resident 28, rubbed Resident 28's back with one bare hand while holding Resident 40's medications in their other hand. LPN-C then administered medication to Resident 40. The benefit of hand hygiene was not completed between residents. An observation on 5/6/2024 at 7:22 AM revealed LPN-C had completed a medication pass for Resident 40. LPN-C did not perform hand hygiene prior to beginning medication pass of the next resident, Resident 5. An interview on 5/6/2024 at 7:30 AM confirmed LPN-C was aware of the need to perform hand hygiene between every resident. A record review of facility policy Handwashing/Hand Hygiene with a last revised date of 2/27/2023 revealed the following: - All personnel shall follow the handwashing/hand hygiene procedures to prevent the spread of infections. - An alcohol-based hand rub should be used before and after direct contact with residents and before preparing or handling medications. - When washing hands, personnel shall rub hands together vigorously for at least 15 seconds. A record review of the Center for Disease Control When and How to Wash Your Hands revealed guidelines to scrub hands for at least 20 seconds.

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NAME OF PROVIDER OR SUPPLIER Kimball County Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 810 East 7th Street Kimball, NE 69145	

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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 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 49263 Licensure Reference Number 172 NAC 12-006.17A(3) Based on record review and interviews, the facility failed to implement an antibiotic stewardship program. This had the potential to affect all residents who resided within the facility. The facility census was 41. The Findings Are: A record review of facility policy Antibiotic Stewardship Program with last review date of 2/27/23, revealed in the Procedure section #5 If indicated, based upon criteria, an antibiotic is ordered, the practitioner will identify the diagnosis/indication, the appropriate antibiotic, proper dose, duration and route. The policy also revealed in #10. Nursing will track antibiotic use and monitor adherence to evidence-based criteria including: a. Documentation related to antibiotic selection and use, b. Tracking antibiotics used to review patterns of use and determination of the impact of the antibiotic stewardship interventions, c. Monitoring for clinical outcomes such as rates of C. difficile infections, antibiotic-resistant organisms or adverse drug events, d. Reporting of communicable disease is done by the testing laboratory, e. Provide reports related to monitoring antibiotic usage and resistance data to the QAA committee. An interview on 5/1/2024 at 7:15 AM with the Administrator confirmed the Assistant Director of Nursing (ADON) was also the facility's Infection Preventionist. A record review of a document, Antibiotic Medications Report: 03/29/2024-04/29/2024 provided by the ADON revealed a report from the facility's EHR which contained a listing of all residents who had been on an antibiotic during the month of April 2024. An interview on 5/6/2024 at 2:25 PM with the ADON revealed the ADON runs a report from the facility's Electronic Health Record (EHR) each month which lists all residents who had been placed on an antibiotic and what the antibiotic was. The ADON confirmed they do not track or trend resident antibiotic use beyond this. An interview on 5/7/2024 at 9:05 AM with the Administrator revealed the facility had struggled with implementing an antibiotic stewardship program.

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	285256	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kimball County Manor	810 East 7th Street Kimball, NE 69145

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49263 Licensure Reference Number 175 NAC 12-006.17 Based on record review and interview, the facility failed to provide a pneumococcal immunization for 1 (Resident 35) of 5 sampled residents. The facility census was 41. The Findings Are: A record review of facility policy Influenza & Pneumococcal Vaccines dated 2/23/23 revealed in the Procedure section, #1. On admission, residents will be interviewed as to immunization status. If pneumococcal vaccine has not been given, the resident/resident representative will be instructed as to the advisability of vaccination, and vaccination shall be given with an order from the physician and resident/resident representative permission, unless contraindicated. #3. If the history of pneumonia or influenza immunization status is unknown, Social Services/Nursing will contact the physician clinic for further records prior to giving the immunization. A record review of Resident 35's medical records revealed a signed pneumococcal vaccine consent form dated 7/5/2023 which indicated the resident had received a pneumococcal vaccine but there was not a date or type of pneumococcal vaccine indicated. The consent form also had may need booster handwritten next to this section of the form. An interview on 5/6/24 at 2:25 PM with the Assistant Director of Nursing (ADON) revealed that Social Services (SS)-D was responsible for entering resident immunization data into the medical records and for scheduling resident immunizations. An interview on 5/6/24 at 3:00 PM with SS-D revealed the facility had not yet looked into whether Resident 35 had previously received the pneumococcal vaccine and that the resident had not received a pneumococcal vaccine while residing in the facility.

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NAME OF PROVIDER OR SUPPLIER: Kimball County Manor		STREET ADDRESS, CITY, STATE, ZIP CODE: 810 East 7th Street Kimball, NE 69145	

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 49263 Based on record review and interview, the facility failed to provide a COVID-19 immunization for 1 (Resident 38) of 5 sampled residents. The facility census was 41. The findings are: A record review of Resident 38's medical records revealed a COVID-19 vaccine consent form, dated 12/11/2023, which the resident had signed acknowledging they wanted to receive the COVID-19 vaccine. A record review conducted on 5/6/2024 of Resident 38's immunization records revealed no evidence that the resident had received a COVID-19 vaccine. An interview on 5/6/24 at 2:25 PM with the Assistant Director of Nursing (ADON) revealed that Social Services (SS)-D was responsible for entering resident immunization data into the medical records and for scheduling resident immunizations. An interview on 5/6/2024 at 3:00 PM with SS-D revealed Resident 38 had not yet been scheduled to receive the COVID-19 vaccine.