STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Community Memorial Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1015 F Street, Burwell, NE 68823	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.04(F)(i)5 Based on record review and interview; the facility staff failed to notify the primary care practitioner (PCP) and the Registered Dietician (RD) of weight loss for 2 (Residents 27 and 12) of 3 residents reviewed. The facility identified a census of 58. Findings are: A. Review of the facility policy Notification of Changes with a revision date of 12/220/22 revealed the purpose of the policy was to ensure prompt notification to the resident's physician and the resident's representative when there was a change requiring notification. Circumstances which required notification included: -accidents resulting in injury or physician intervention. -significant change in the resident's physical, mental, or psychosocial condition. -circumstances that required a need to alter treatment. -a transfer or discharge from the facility. -a change in the resident's rights. -a change in the resident's roommate. B. Review of a Weights and Vitals Summary Sheet (form used to document a resident's weights, blood pressure, respirations, temperature, and pulse) revealed the following weights for Resident 27: -4/30/24 weight was 152 pounds. -5/27/24 weight was 148 pounds (down 4 pounds in 1 month). -6/27/24 weight was 140 pounds (down 8 pounds or a 5% loss in 1 month). (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7/29/24 weight was 139 pounds. -8/22/24 the resident's weight was 130 pounds (down 9 pounds in 1 month or a 6% loss in 30 days). Review of the resident's electronic medical record revealed no evidence the RD or the PCP were notified of the resident's ongoing significant weight loss. An interview with the Dietary Manager on 11/19/24 at 1:59 PM confirmed the following regarding Resident 19: -6/27/24 the resident had a weight loss of 8 pounds or a 5% loss in 1 month. -8/22/24 the resident had a weight loss of 9 pounds or a 6% loss in 30 days. -the RD and the PCP were not notified of Resident 27's ongoing weight loss. C. Review of a Weights and Vitals Summary Sheet for Resident 12 revealed the following: -9/29/24 weight was 149 pounds. -10/31/24 weight was 132 pounds (down 17 pounds or a 11% weight loss in 30 days). During an interview on 11/20/24 at 4:04 PM, the DM confirmed the resident's PCP, and the RD were not notified after the resident's weight on 10/31/24 revealed a 17 pound or an 11% loss in 1 month.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42360 Licensure Reference Number 175 NAC 12-006.09(A) Based on record review and interview; the facility failed to ensure Level 1 Preadmission Assessment and Resident Review (PASARR-screening process required to be completed prior to admission to ensure residents with Serious Mental Illness (SMI), Intellectual Disability(ID), Development Disability(DD) or Related Disorders (RD) met the criteria for Nursing Home admission and had any additional services needed) screens were completed accurately prior to admission for Residents 48 and 44. The sample size was 3 and the facility census was 58. Findings are: A. Review of the facility policy Resident Assessment-Coordination with PASARR Program with a revision date of 7/18/24 revealed the following: -The facility coordinated assessments with the PASARR program under Medicaid to ensure that all individuals with a mental disorder, intellectual disability, or a related condition received care and services in the most integrated setting appropriate to their needs. -All applicants to the facility were screened for SMI or ID and RC in accordance with the State's Medicaid rules for screening. -Level 1 screening was completed prior to admission and a negative screen allowed the facility to proceed with admission and ended the PASARR process, a positive screen necessitated level 2 evaluation completed by the appropriate designated authority to determine appropriateness of setting for the individual and any recommendations for specialized services. B. Review of Resident 48's Minimum Data Set (MDS-federally mandated assessment used to development resident Care Plans) dated 10/12/24 revealed the following: -The resident had a level 1 PASARR, -had diagnoses of a Psychotic Disorder and Post Traumatic Stress Disorder (PTSD), and -received antipsychotic, antianxiety, and antidepressant medications. Review of Resident 48's PASARR dated 11/28/23 revealed no evidence the screen included any mental illness diagnosis. Review of Resident 48's Care Plan with a revision date of 5/9/24 revealed diagnoses of Anxiety Disorder, Depression, and PTSD and the resident was at risk for adverse reactions to medication. The resident had hallucinations, delusions, and insomnia. In addition, the resident could become aggressive and resistive to care. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/19/24 at 3:40 PM the Director of Nursing (DON) confirmed the facility had not checked the accuracy of Resident 48's Level 1 PASRR screen at the time of admission to ensure it was completed accurately and to ensure the resident did not need a level 2 (screen completed by an outside source to determine if the resident had SMI/ID/DD/RD in order to establish if the resident needed additional services not routinely provided by nursing facilities) screen. In addition, the DON confirmed the resident did have a diagnosis of a delusional disorder, anxiety disorder, depression and PTSD that was not included on the 11/28/23 Level 1 screen. C. Review of Resident 44's MDS dated [DATE] revealed the resident had a level 1 PASARR screen and had diagnoses of an anxiety disorder and bipolar disorder and took antipsychotic, antianxiety, and antidepressant medication. Reviewed of Resident 44's PASARR level 1 screen dated 5/21/24 indicated the resident had no Major Mental Illness. There was no indication the bipolar disorder or anxiety disorder was included on the level 1 screen. Review of Resident 44's Orders revealed the following: -5/16/24 Buspirone HCl (antianxiety medication) Oral Tablet 10 MG Give 10 mg by mouth two times a day related to a generalized anxiety disorder, -5/17/24 aripiprazole (antipsychotic medication) Oral Tablet 15 MG Give 15 mg by mouth one time a day related to bipolar disorder, and -The resident was taking psychoactive (mind altering) medications with Target Behaviors of agitation, very regimented, easily irritable, health concerns, and impatient. Review of Resident 44's Care Plan with a revision date of 10/29/24 revealed the resident displayed verbal and physical aggression and was at risk for adverse reactions to medications, took antipsychotic, and hypnotic (sleep inducing) medications and was monitored for side effects and effectiveness. During an interview on 11/19/24 at 3:40 PM the Director of Nursing (DON) confirmed the facility had not checked the accuracy of Resident 44's Level 1 PASARR screen at the time of admission to ensure it was completed accurately, and to ensure the resident did not need a level 2 screen. In addition, the DON confirmed the resident did have diagnoses of bipolar disorder and anxiety disorder that was not on the Level 1 screen.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.09(F) Based on observation, record review, and interview; the facility failed to implement and/or revise Residents 1, 29, 54, and 59's current care plans to reflect the resident's current status. The sample size was 22 and the facility census was 58. Findings are: A. Review of the facility policy Comprehensive Care Plans with a revision date of 12/14/2022 revealed the following: -It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs. The care planning process will include resident's strengths and needs, -The care plan will be developed within 7 days after the completion of the comprehensive Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) assessment, -The care plan will describe services that are to be furnished to attain or maintain the resident's physical, mental, and psychosocial well-being, -The care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment, B. Review of Resident 29's MDS dated [DATE] revealed the resident was cognitively intact; was dependent with dressing, transfers, bed mobility, and toileting; had diagnoses of dementia, Parkinson's Disease, anxiety, and depression; received antipsychotic and antidepressant medications; was at risk for pressure ulcers, had pressure relieving devices for their chair, bed, and was on a turning/repositioning program. Review of Resident 29's Care Plan last revised 10/3/24 revealed the resident received antidepressant medications (Sertraline and Trazodone), antipsychotic medications (Quetiapine), and was dependent with bed mobility, dressing, transfers, and toileting. The resident was at risk for skin breakdown and staff was to follow treatments as ordered on the Treatment Administration Record (TAR). There was no documentation on the Care Plan that the resident had any Pressure sores or was on Enhanced Barrier Precautions (EBP-an infection control intervention designed to reduce transmission of Multi-Drug Resistant Organisms [MDRO's]). Review of Resident 29's TAR for November 2024 revealed orders for: -change foam heel cup every Tuesday for deep tissue injury (damage to the soft tissue beneath the skin caused by pressure or shear forces) ordered 9/24/24, and (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-paint left and right heel wounds with betadine, allow to dry, and then apply skin prep to site twice a day until healed, then place heel protector over site ordered 10/14/24. Observations of 11/18/24 at 11:10 AM an EBP sign was located on Resident 29's Bathroom door. Observation on 11/20/24 with Licensed Practical Nurse (LPN-M) at 7:30 AM revealed LPN-M performed hand hygiene and donned a gown and gloves. LPN-M uncovered the resident and placed a pad to soak up drainage underneath the resident's legs. LPN-M removed the foam heel cup from both of the resident's heels. LPN-M stated the resident had sores to both heels that had black eschar (a dark, hard, dry covering) to both areas. LPN-M completed the treatment as ordered, then applied lotion to the resident's legs. LPN-M removed their gown and gloves, and hand hygiene was performed without identified concerns. Interview on 11/19/24 at 11:30 AM with LPN-M revealed Resident 29 had EBP for on-going heel wounds. Interview on 11/20/24 at 3:10 PM with the MDS Nurse confirmed the residents pressure areas and EBP were not implemented onto Resident 29's Care Plan. Interview on 11/20/24 at 3:55 PM with the Director of Nursing (DON) confirmed Resident 29's care plan did not include pressure areas and that the resident was on EBP. 51391 C. Review of Resident 59's MDS dated [DATE] revealed the following regarding the resident: -resident was dependent on staff for toileting cares, bathing, lower body dressing, personal hygiene, and no transfer was attempted -resident required substantial assistance with upper body dressing, -resident required moderate assistance with brushing teeth and set up assistance with eating meals, -resident was always incontinent of bowel and had constipation, -resident had an indwelling catheter, -resident received pain medications and frequently had pain that constantly affected day to day activities, -resident had a stage 3 pressure ulcer with pressure ulcer care, and -resident had a diagnosis of an MDRO and arthritis. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation of the provision of care for Resident 59 on 11/18/24 at 10:30 AM, LPN-E and Nurse Aide (NA)-D entered Resident 59's room to complete peri-cares, catheter cares and to reposition the resident. An EBP sign was on the wall of Resident 59's room. LPN-E and NA-D washed their hands and put on disposable gowns and gloves. Resident 59 was incontinent of a small bowel movement and the staff completed catheter cares and peri cares. LPN-E did not remove or change gloves after completing peri cares or catheter cares. LPN-E and NA-D changed the residents bottom sheet and put on a clean incontinence brief. LPN-E removed the disposable gown and gloves and washed hands but failed to reapply gloves or a gown. LPN-E assisted to reposition the resident, adjusted the bed linens, pillows, and the catheter tubing without use of the required gown and gloves. Review of Resident 59's care plan dated 11/1/24 revealed that there was no care plan initiated for Activities of Daily Living (ADL's), Indwelling Catheter (a tube inserted into the bladder to drain the urine), falls, pressure ulcer, Hospice Care, Pain, and Constipation. Interview with MDS Nurse on 11/21/24 at 9:30 AM verified that no constipation care plan was in place for Resident 59. D. Review of Resident 54's MDS dated [DATE] revealed the following regarding the resident: -resident was dependent on staff for oral hygiene, toileting cares and bathing, -resident required substantial assistance with eating, dressing, footwear and transfers, -resident required moderate assistance with bed mobility, -resident was occasionally incontinent of bowel, -resident was frequently incontinent of urine, and -resident received antipsychotic and antianxiety medications. Review of Resident 54's care plan with a revision date of 9/7/24 revealed that nursing care plans regarding the above ADL's had not been reviewed/revised since 6/24/24. A interview with the MDS Nurse on 11/19/24 at 2:45 PM revealed that the care plan for Resident 54 had not been reviewed/revised since 6/24/24. E. Review of Resident 1's MDS dated [DATE] revealed the following regarding the resident: -resident required substantial assistance with toileting cares, lower body dressing, footwear, personal hygiene, transfers and walking short distances, -resident required moderate assistance with oral hygiene, bathing cares, upper body dressing, -resident was independent with wheelchair mobility, -resident was always continent of bowel, (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-resident had an indwelling catheter, and -resident felt down and depressed, had trouble sleeping, was tired and had trouble concentrating. Review of Resident 1's care plan revealed that resident had a diagnosis of anxiety, depression, psychotic disorder, schizophrenia, and MRSA. Resident 1's care plan last revised 8/10/24 revealed that there were no interventions in place for impaired cognition and activities care plans. The nursing care plan goals had not been reviewed and updated since 8/10/24 and MDRO was not on the care plan. Quarterly MDS was completed 10/23/24. During an observation of the provision of care for Resident 1 on 11/19/24 at 10:30 AM LPN-L completed suprapubic catheter cares (tube that goes into the bladder through the abdominal wall which drains urine from the bladder, cares include washing and drying the skin around the catheter site). EBP sign was on the wall when entering the room. LPN-L washed hands and put on a disposable gown and gloves then removed the sponge dressing from around the supra-pubic catheter which was heavily soiled with urine. LPN-L cleansed and dried the skin around the catheter and applied a clean sponge dressing to the insertion site. LPN-L then removed soiled gloves and washed hands. A interview with the MDS Nurse on 11/19/24 at 2:45 PM confirmed the Falls, ADL, Pressure Ulcer and Indwelling Catheter care plans for Resident 59 were initiated on 11/19/24 and they should have been in place by 11/1/24. The MDS Nurse confirmed Resident 54's care plan had not been reviewed or updated after the care plan meeting from 9-7-24 and MDRO is not on Resident 1's care plan. Interview with MDS Nurse on 11/20/24 at 2:30 PM confirmed that care plans were to be reviewed and revised after each MDS assessment.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 51391 Licensure Reference Number 175 NAC 12-006.09(H)(iv) Based on interview and record review; the facility failed to ensure Resident 59's Bowel and Bladder management plan was coordinated and addressed in cooperative with the Hospice Care provider. The sample size was 1 with a census of 58. Findings are: A. Review of the undated facility policy Bowel Elimination revealed the following: The facility developed and implemented a process to assure that constipation was prevented/addressed in a timely fashion. Daily documentation of bowel elimination was reviewed. The night shift ran a report showing no Bowel Movement (BM) in the last 48 hours and no BM in the last 72 hours. The following steps were followed for all residents of Community Memorial Health Center: - If no BM in 48 hours the dietary staff was notified and the resident was offered bran flakes, prune juice or both. - If no BM in 72 hours the resident was offered Milk of Magnesia (laxative), 30 cubic centimeters (cc) by mouth. - If no BM for 4 days the resident was offered a Dulcolax Suppository (laxative) Rectally. - If no BM for 5 days the resident was offered a Fleets Enema (injection of liquid into the rectum to cause the intestines to empty). B. Record review of Nursing Assistant (NA), documentation dated 11/1/24 through 11/16/24 revealed no BM was documented. Review of Nursing Note Documentation revealed: -On 11/6/2024 at 1:10 AM Resident 59 was given a fleets enema and had not had a BM for 7 days. The resident had nausea and was given Zofran (Medication for nausea), and the resident was educated about the complications of constipation. -On 11/10/2024 at 11:41 PM The resident had a BM on 11/7/24 and a suppository had been given. -On 11/20/2024 at 2:44 PM bowel management medication was discussed with the hospice nurse and a routine laxative was initiated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the resident's Medication Administration Record (MAR) dated 11/24 revealed that the resident received Milk Of Magnesia on 11/4/24 with no BM, on 11/5/24 the resident refused medications offered, on 11/6/24 the resident received a enema and had a BM, on 11/9/24 the resident received Milk Of Magnesia with no BM, per nursing note documentation resident received a suppository on 11/10/24, on 11/15/24 the resident received Milk Of Magnesia with no BM, on 11/16/24 the resident received a suppository and had a BM. The resident had an order for Polyethylene Glycol Powder 17 gram (Laxative) by mouth every 24 hours as needed for constipation and the medication had not been administered for the month of 11/24. Review of the Hospice Certification and Plan of Care dated 10/16/24 revealed that Resident 59 was admitted to Hospice Care on 10/16/24. Review of Hospice Order dated 10/16/24 revealed: - The Hospice Nurse was to assess and instruct the resident/caregiver on factors that increased the risk of constipation and measures to prevent constipation. The Hospice Goal dated 10/16/24 revealed: -The Resident/Caregiver verbalize understanding of risk factors that increased the risk of constipation and measures to prevent constipation. Review of Resident 59's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 10/26/24 revealed that the resident had constipation. Review of Resident 59 facility Care Plan dated 11/19/24 revealed no evidence constipation was addressed. During an interview with the Director of Nursing (DON), on 11/20/24 at 7:45 AM, the DON confirmed that Resident 59 received medications as needed for bowels but not routinely, and the resident bowel medications had not been reviewed as the resident did not get out of bed, activity level was limited, and resident's intake was poor. During an interview on 11/20/24 at 2:05 PM with Licensed Practical Nurse, (LPN-Q) from Hospice, confirmed that the facility staff had not voiced any constipation concerns for Resident 59. During an interview on 11/21/24 at 9:30 AM with Registered Nurse (RN-R), confirmed that Resident 59 did not have a constipation care plan in place.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42360 Licensure Reference Number 175 NAC 12-006.I(i) Based on observation, interview, and record review; the facility failed to ensure Residents 14 and 16's falls were reviewed for causal factors, fall prevention interventions were based on causal factors, and reviewed and revised to prevent ongoing falls. The sample size was 4 and the facility census was 58. Findings are: A. Review of the facility policy Fall Prevention Program dated 8/3/23 revealed the following: -Each resident was assessed for fall risk and received care and services in accordance with their individualized level of risk to minimize the likelihood of falls. -The facility used standardized risk assessment to determine a resident's fall risk, and initiated interventions that decreased the risk of falling including but not limited to a clear pathway to the restroom, locking of bed wheels, leaving call lights accessible, providing adequate lighting, and keeping equipment in good repair. In addition, the facility implemented routine rounding, monitoring residents for changes in condition, encouraged residents to wear shoes or slippers with non-slip soles, ensured eyeglasses were clean and were being worn, and reassessed fall risk every 90 days. -At Risk for Falls care plans included adequate supervision, consistent with the resident's needs, goals, and current standards of practice to reduce accident risk. -Care Plan interventions were monitored and modified as necessary in accordance with current practice standards. B. Review of Resident 16's Minimum Data Set (MDS-federally mandated assessment used to development resident care plans) dated 9/28/24 revealed the resident had Cancer and received partial assistance with bathing, dressing, hygiene, and mobility. The resident had frequent moderate pain of 5 out of 10. Review of Resident 16's Morse Fall Scale assessments dated 6/7/24 through 9/26/24 revealed the resident was at High Risk for Falling. Review of Resident 16's Incident Reports revealed the following: -On 5/31/24 at 11:08 PM the resident attempted a self-transfer from a wheelchair to a recliner and fell . The resident reported getting feet stuck to the floor. The intervention was Resident is not to wear crocs . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/6/24 at 3:30 PM the resident activated a call for assistance and staff found the resident sitting on the floor in front of a recliner. The resident had removed shoes, had no socks on and the electric recliner was found in the up position. The resident reported sliding off the recliner onto the floor. The intervention was for the resident to wear gripper socks, the recliner remote was to be left out of the resident's reach and a sign was placed in the resident's room for a reminder. -On 6/22/24 at 3:45 PM the resident was found lying on the floor between the recliner and the bed. The intervention was to re-educate staff to keep the recliner remote out of the reach of the resident. - On 8/20/24 at 3:45 PM the resident slipped on a slightly wet floor and was subsequently lowered to the floor. The intervention was to use a gait belt (belt used around the waste for safety and support during transfers) with transfers, unsure the resident wore proper footwear, and ensuring the bathing room floor was dry before transferring. There was no evidence this was not a facility standard already in place. -On 8/23/24 at 10:15 AM the resident attempted to self-transfer was heard calling out and was found in a kneeling position on the floor. The resident reported needing to go to the bathroom. The intervention was the resident agreed to request assistance, there was no evidence this was a new intervention. -On 10/15/24 at 3:00 PM the resident activated a call light in the bathroom and was found sitting on the floor beside the toilet. The intervention was the resident was re-educated to activate call light prior to attempting a self-transfer, staff were to provide continuous reminders, and signs were placed in the resident room and bathroom. There was no evidence this was a new intervention. During an observation of the provision of toileting assistance for Resident 16 on 11/20/24 at 9:18 AM the resident called for assistance to the toilet. Nurse Aide (NA)-O responded and provided assistance to transfer the resident from the wheelchair to the toilet. No gait belt was used. The resident was then transferred back to the wheelchair and into a recliner and again, a gait belt was not used. During an interview on 11/20/24 at 9:20 AM, NA-O revealed having worked in the facility for 4 years. When questioned about fall prevention measures NA-O knew Resident 16 was assisted with transfers and had dycem in the wheelchair. In addition, staff were to monitor for attempts to self-transfer and are aware of the residents fall risk. NA-O was unaware of any other specific fall prevention interventions. Review of the Resident 16's Care Plan with a revision date of 9/24/24 revealed the following problems, interventions, and implementation dates: 1/18/23 -The resident was at risk for falling. 1/18/23 - encourage periods of rest to prevent over tiring, grab bars in the bathroom, keep floor and pathways clear of clutter, call light in place and provide orientation to call light with cares, 6/30/23 - keep door open for observation, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Community Memorial Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1015 F Street Burwell, NE 68823	

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/30/23 - therapies as needed, 8/26/23 - use of an assistive device per resident's needs, 10/24/23 - Dycem (non-skid mat) on recliner seat, 12/18/23 - Complete Morse Fall Assessment (Assessment used to determine fall risk) upon admission, readmission, quarterly, and as needed. 1/18/24 - call light in place and orientation to call light with cares, 6/12/24 - absolutely no crock shoes, 6/19/24 - non-slip socks and shoes on, 9/5/24 - signage placed in multiple places in room to remind resident to use call light, staff educated to use gait belt, proper footwear and to assure floor is dry before transferring, and 9/24/24 - per family, recliner remote within reach, family aware and educated on risk due to resident having frequent falls related to setting recliner up without assistance and falling. There was no evidence the resident Care Plan was reviewed and/or revised following the resident's falls on 8/20/24, 8/23/24, or 10/15/24 based on causal factors. During an interview on 11/20/24 at 12:33 PM the Director of Nursing (DON) confirmed the resident had fallen several times, and although the facility reviewed falls, they had not identified causal factors with all falls and implemented prevention measures related to the causes and/or or ensured that all fall prevention measures were updated on the resident's care plan. In addition, the DON confirmed staff were to be using gait belts for assisted transfers with Resident 16. C. Review of Resident 14's MDS revealed the resident had 1 fall with no injury. In addition, the resident was severely impaired cognitively, displayed disorganized thinking, inattention, and altered levels of consciousness. The resident received assistance with eating, hygiene, dressing, bathing, transfers, and bed mobility. Diagnoses included dementia, schizophrenia, arthritis, and heart disease. Review of Resident 14's Morse Fall Scales on 6/14/24-10/31/24 revealed the resident was at risk for falling. Review of Resident 14's Incident reports revealed the following: -On 6/19/24 at 6:45 AM the resident was observed on the floor in front of the toilet with regular socks rather than gripper socks on. The intervention was to use gripper sock and a Tabs monitor (alarm with a pull tab secured to the resident that is supposed to alarm and alert staff if the resident tries to get up unassisted), and staff were to check on resident right after morning shift change and get the resident up and dressed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 6/26/24 at 3:30 AM the resident was found lying on the floor between the bed and the bathroom door. Staff determined the resident removed the TABS alarm and walked without walker a walker toward the bathroom. The intervention was to ensure the resident's walker was left in reach. It was unclear whether this was a new intervention and was not on the Care Plan. -On 10/9/24 at 3:30 PM the resident was found lying on the floor between the closet and the bed. The resident had been toileted 15 minutes prior but had since removed shoes and did not have on gripper socks. The resident did not use call light for assistance. The resident was determined to be confused and there was no new intervention documented. -On 10/22/24 at 6:30 PM the resident was found on the floor next to the bed. Staff believe she may have been trying to get into the unmade bed. The intervention was to take the resident to the dining room first while they were busy getting other residents to the dining room. In addition, staff were to place 2 wedge cushions on the resident's bed. -On 10/31/24 at 1:30 AM the resident was found on floor on the bedside fall mat. It was determined the wedged were not in place and the intervention was staff education provided. -On 11/16/24 at 8:10 AM the resident was found on the floor of another resident's room. The intervention for to staff to be aware of the resident's location every hour. Review of Resident 14's Care Plan with a revision date of 10/24/24 revealed the following: -6/12/24-The resident was at risk for falling, -6/12/24 the following interventions were added to the care plan (call light in place and orientation to the call light with cares, Morse Fall Scale to be completed with admission/readmission, quarterly and as needed, Encourage rest periods to prevent over tiring, low-bed with bed placed against the wall, never leave alone on the toilet, non-slip sock/shoes on, observe for behaviors and address appropriately, and 1 hour safety checks), -6/19/24 resident to be checked on after morning shift change and dressed if awake during rounds, -10/24/24 fall mat to outer side of the bed, wedges x 2 to outer side of bed, -11/3/24 resident to lie in bed after lunch, toilet around 3:00 PM and place in w/c in hallway for monitoring, -11/12/24 resident will purposefully crawl over wedges and place self on There was no evidence the resident Care Plan was reviewed and or revised following the resident's falls on 6/19/24 (to include the use of a TABS monitor), 10/9/24, or 11/16/24 based on causal factors. During an interview on 11/19/24 at 9:26 AM Nurse Aide-F confirmed that Resident 14 was at risk for falling and knew staff were to ensure the residents needs were met, ensure the resident's bed with in a low position with a bed side fall mat, assist the resident as needed to the toilet, make sure the resident's call light was accessible, and engage the resident in an activity when possible. (continued on next page)

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	285257	A. Building B. Wing	11/21/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 11/20/24 at 12:33 PM the DON confirmed that although the facility reviewed fall, they did not always identify causal factors and implement prevention measures related to those causes or ensure that all fall prevention measures were updated on the Resident 14's care plan.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 Licensure Reference Number: 12-006.09(J)(i)(1) Based on observations, record review, and interviews; the facility failed to identify and monitor ongoing weight loss and to implement and/or revise interventions to prevent further weight loss for 1 (Resident 27) of 3 sampled residents. The facility census was 58. Findings are: A. Review of the facility Weight Monitoring policy with a revision date of 7/2/24 revealed the facility was to ensure all residents maintained acceptable parameters of nutritional status unless the resident's clinical condition demonstrated this was not possible or the resident's preferences indicated otherwise. The following guidelines were identified: -to optimize a resident's nutritional status by identifying the resident's nutritional status and risk factors, developing, and consistently implementing weight loss interventions, and monitoring the effectiveness of interventions and revising, as necessary. -Registered Dietician (RD) and the physician to be notified and to assist with interventions; and -RD and Dietary Manager (DM) to continue to follow until weight was stable. B. Review of Resident 19's Minimum Data Set (MDS-a federally mandated comprehensive assessment tool used for care planning) dated 9/9/24 revealed the resident was admitted [DATE] with diagnoses of major depressive disorder, Parkinson's disease, non-Alzheimer's dementia, restlessness, agitation, and chronic obstructive pulmonary disease. The assessment indicated the resident's cognition was moderately impaired and required partial to moderate assistance with eating and/or drinking. The resident's weight was 128 pounds, and the resident had a weight loss of 5 percent (%) in the last month or a loss of 10% or more in the last 6 months. Review of the resident's admission orders dated 3/22/24 revealed an order for a milkshake every afternoon for additional calories. Review of a Nutritional Progress Note dated 4/18/24 at 9:46 AM revealed the RD completed an admission assessment of the resident's nutritional status. The resident was consuming 75-100% of food at meals and was receiving a milkshake once a day for added calories. No additional interventions were identified. Review of a Weights and Vitals Summary Sheet (form used to document a resident's weights, blood pressure, respirations, temperature, and pulse) revealed the following weights: -4/30/24 weight was 152 pounds. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	-5/27/24 weight was 148 pounds (down 4 pounds in 1 month). -6/27/24 weight was 140 pounds (down 8 pounds or a 5% loss in 1 month). Review of the resident's electronic medical record revealed no evidence the RD evaluated the resident's 5% weight loss or developed additional interventions to prevent further loss. Review of the resident's Weights and Vitals Summary Sheet revealed on 7/29/24 the resident's weight was 139 pounds and on 8/22/24 the resident's weight was 130 pounds (down 9 pounds in 1 month or a 6% loss in 30 days). Review of a Nutritional Progress Note by the RD dated 8/24/24 at 2:25 PM revealed the resident had a severe weight loss in 30 days of 6.5% and 12.2% in the last 90 days. The DM indicated the resident's spouse was in the hospital and no longer provided the resident with snacks in the resident's room. A new intervention was identified for the resident to receive a snack every morning at 10:00 AM. Review of Resident 19's Weights and Vitals Summary Sheet revealed on 9/30/24 the resident weight was 131 pounds and on 11/15/24 the resident's weight was 133 pounds. An interview with the Dietary Manager on 11/19/24 at 1:59 PM confirmed the following regarding Resident 19: -admitted with an order for a milkshake every afternoon as the resident had a history of weight loss. -6/27/24 the resident had a weight loss of 8 pounds or a 5% loss in 1 month. -8/22/24 the resident had a weight loss of 9 pounds or a 6% loss in 30 days. -the RD had not evaluated the resident since the initial assessment completed on 4/18/24. No additional nutritional interventions were developed despite the resident's ongoing weight loss. -8/24/24 the RD initiated a morning snack for the resident due to weight loss. -the resident's weight on 11/15/24 was 133 pounds.

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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. 42360 Licensure Reference Number 175 NAC 12-006.09(H) Based on record review and interview; the facility failed to ensure antibiotics were given in accordance with the facility Antibiotic Stewardship Program (ASP-program for optimizing treatment of infections and reducing adverse events from the use of antibiotics) for Resident 16. The sample size was 5 and the facility census was 58. Findings are: A. Review of the facility undated Antibiotic Stewardship Program policy revealed the following: -It was the policy of the facility to implement and Antibiotic Stewardship Program (ASP) as part of the facilities overall infection prevention and control program. -The purpose of the program was to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. -The Infection Preventionist, with oversight from the Director of Nursing served as the leader of the Antibiotic Stewardship Program and received support from the Administrator and other governing officials of the community. -The Medical Director, Consultant Pharmacist, and Attending Physicians supported the ASP through active participation in developing, promoting, and implementing a facility wide system for promoting, and implementing a facility-wide system for monitoring the use of antibiotics. -Antibiotic use protocols including nursing assessment prior to physician notification, laboratory testing in accordance with practice standards, criteria to determine whether to treat infection with antibiotics, and ensuring all antibiotics specified dosing, duration, and indication for use. Review of Resident 44's Minimum Data Set (MDS-federally mandated assessment used to development resident Care Plans) dated 9/28/24 revealed the resident received antibiotics in the preceding 7 days. Review of the Note to Attending Physician Form sent to the physician from the Consultant Pharmacist dated 1/16/24 revealed the Consultant Pharmacist sent a recommendation letter to the physician requesting clarification of the Bactrim DS order. The document stated the resident had been taking the Bactrim DS since 6/12/23. Further review revealed the physician included a diagnosis of Pneumonitis (inflammation of the lungs) and checked a box to continue the medication but documented no clinical rationale or supporting evidence to support the continued use of an antibiotic. Review of Resident 44's Physician's Orders dated 11/20/24 revealed the following medication: - Sulfamethoxazole-Trimethoprim Oral Tablet 800-160 MG (Bactrim DS) Give 1 tablet by mouth two times a day every Monday, and Thursday. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/24 at 2:22 PM the Director of Nursing confirmed the resident continued routine use of the antibiotic Bactrim DS without a stop date, and the provider had not documented a clinical rationale in accordance with the facility Antibiotic Stewardship Program for continued use of an antibiotic without a stop date or predetermined course duration.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45739 Licensure Reference Number 175 NAC 12-006.12(A) Based on record review and interview; the facility failed to attempt a Gradual Dose Reduction (GDR) of Residents 24, 26, and 29's psychotropic medications (medications which alter consciousness, mood, and thoughts) or to have a documented clinical rationale for continued use. The sample size was 5. The facility census was 58. Findings are: A. Review of the facility policy Use of Psychotropic Medications, implemented on 10/6/23 revealed the following: -a psychotropic drug was any drug that affected brain activities associated with mental processes and behavior. Psychotropic drugs included: antipsychotics, antidepressants, anti-anxiety, and hypnotics, -the indications for the use of the medications would be determined by assessing the underlying condition, current signs, symptoms, expressions, and preferences and goals for treatments, and identifying of underlying causes, when possible, -the attending physician would assume leadership in medication management by developing, monitoring, and modifying the medication regimen, -the indications for use of any psychotic drug would be documented in the medical record, -documentation would include the specific condition as diagnosed by the physician, -residents who used psychotropic drugs would receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs, -the effects of the psychotropic medications would be evaluated on an on-going basis, and -the residents' response to the medications, including progress towards goals and presence/absence of adverse consequences would be documented in the resident's medical record. B. Review of Resident 24's Minimum Data Set (MDS-a federally mandated assessment tool used in care planning) dated 9/28/24 revealed the resident had severe cognitive impairment; diagnoses included depressive disorder and anxiety; Resident 24 received antipsychotic and antidepressant medications, and required assistance with dressing, and toileting. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 24's Care Plan last revised 11/18/24 revealed the resident had impaired cognition; had dementia; was at risk for elopement; had behaviors of tearfulness, and difficulty redirecting; received medications for antianxiety (Risperdal) and antidepressants (Mirtazapine, Trazodone, Sertraline); and required assistance with bed mobility, dressing, hygiene, and toileting. Review of the facility forms Note to the Attending Physician/Prescriber regarding Resident 24 revealed the following: -on 5/22/24 a GDR was due for Sertraline. The Physician marked the dose reduction was contraindicated due to behaviors noted in the care plan and charting. An area marked Please fill in a patient specific reason as to why reduction is contraindicated was left blank, and -on 7/17/24 GDR's were due for the Risperdal, Mirtazapine, and Trazodone. The Physician marked the dose was contraindicated due to behaviors noted in the care plan and charting for Risperdal. For Remeron and Trazodone, the Physician marked dosage reduction is contraindicated. An area marked Please fill in a patient specific reason as to why reduction is contraindicated was left blank. C. Review of Resident 29's MDS dated [DATE] revealed the resident was cognitively intact, was dependent with dressing, transfers, bed mobility, and toileting, had diagnoses of dementia, Parkinson's Disease, anxiety, and depression, and received antipsychotic and antidepressant medications. Review of Resident 29's Care Plan last revised 10/3/24 revealed the resident received antidepressant medications (Sertraline and Trazodone), antipsychotic medications (Quetiapine), and was dependent with bed mobility, dressing, transfers, and toileting. Review of the facility forms Note to Attending Physician/Prescriber regarding Resident 29 revealed the following: -on 2/14/24 GDR's were due for Quetiapine, Sertraline, and Trazodone. The Physician did reduce the Quetiapine, but marked dosage reduction is contraindicated for Sertraline and Trazodone. An area marked Please fill in a patient specific reason as to why reduction is contraindicated was left blank, and -on 7/17/24 GDR's were due for Seroquel, Trazodone, and Sertraline. The Physician marked dosage reduction is contraindicated due to behaviors noted in the care plan and charting for the Seroquel. Dosage reduction is contraindicated was marked for Trazodone and Sertraline. An area marked Please fill in a patient specific reason as to why reduction is contraindicated was left blank. D. Interview with the Director of Nursing (DON) on 11/20/24 at 11:55 AM confirmed the GDR's did not have rationale's for contraindications documented that was specific to Resident 24 or Resident 29 and there should have been a rationale's documented. 29638 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Review of Resident 26's MDS dated [DATE] revealed the resident was admitted [DATE] with diagnoses of Parkinson's disease, cancer, anemia, coronary artery disease, renal failure, diabetes, depression, bipolar disorder, and non-Alzheimer's dementia. The resident was assessed as having moderate cognitive impairment, with behaviors of delusions and hallucinations. The resident had physical/verbal behaviors directed toward others, other behavioral symptoms not directed toward others, and rejection of cares. The resident was identified as receiving antipsychotic and antidepressant medications. Review of the resident's Care Plan with a revision date of 1/25/23 revealed the resident had paranoia, hallucinations, delusions, verbal, and physical aggression and indicated the resident received psychoactive medications. Review of the facility form Note to the Attending Physician/Prescriber with a date of 11/15/23 revealed the resident was due for a GDR of the following medications: -Depakote (antiseizure medication used to treat some psychiatric conditions) 125 milligrams (mg) three times a day. -Zyprexa (antipsychotic medication used to treat mental health disorders) 5 mg daily. -Risperdal (antipsychotic medication used to treat mental health disorders) 1 mg twice a day. -Trazadone (medication used to treat depression) 100 mg daily. The note requested the resident's physician evaluate use of these medications for a potential GDR. Further review revealed the physician denied a GDR due to the resident's behaviors. No specific reason was identified as to why the GDR was contraindicated. During an interview on 11/20/24 at 12:05 PM, the DON confirmed Resident 26's physician failed to document a specific clinical rational as to why a GDR of the resident's psychoactive medications were clinically contraindicated.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.11D Based on observation, record review and interview; the facility failed to ensure meals served in the Special Care Unit (SCU) were palatable and served at the proper temperature. This had the potential to affect all 16 residents that resided on the SCU. The facility census was 58. Findings are: A. Review of the facility policy Record of Food Temperatures (undated) revealed it was the policy of this facility to record food temperatures daily to ensure food was served at the proper temperature. The following guidelines were to be followed: -food temperatures were to be recorded on all items prepared in the dietary department. -hot food items were to be maintained at 135 degrees Fahrenheit (F) or higher. -potentially hazardous food that was cooked and then cooled was to be reheated so that all parts of the food reached an internal temperature of 165 degrees (F) for at least 15 seconds before service. -ready to eat foods that required heating before consumption were to be taken directly from a sealed container of an intact package from an approved food processing source and heated to at least 135 degrees (F) before holding for hot service. B. Education to the staff working on the SCU regarding food temperatures out of the Hot Boxes (undated) revealed the following process to follow: -staff were to take the temperature of one food item from the first and the last plate served to ensure palatable food temperatures were maintained. -all hot items being held for service needed to have a temperature of 135 degrees (F) or greater. -with the first plate, staff were to pick any one item on the plate and obtain a temperature by holding the thermometer in place for 10-15 seconds to give the digital read out time to finishing temping. The food item needed to reach 135 degrees (F). -if the temperature was below 135 degrees (F), staff were to place the plate in the microwave until the temperature came up to 165 degrees (F) for a total of 15 seconds. If the first plate does not have a temperature of 135 degrees (F) you will most likely need to heat all other plates to ensure a palatable food temperature. -document the name of the food item and the temperature on the food log and sign yes or no if corrective action (reheating the food in the microwave) was taken. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-staff were to repeat this process for the last plate using the same food item used for the first plate. -if the food did not maintain the correct temperature, staff were to notify the cook or the Dietary Manager (DM) so they could identify and resolve the problem. C. Interview with the DM on 11/19/24 at 1:59 PM revealed the kitchen staff were to check food temperatures from food held on the steam table. Each food item needed to be at least 135 degrees (F) before plating and packaging in the Hot Box for the SCU. Observations on 11/21/24 from 8:00 AM to 8:40 AM revealed the following: -8:10 AM the Hot Box was delivered by the dietary department and was left in the SCU dining room. -8:13 AM the Director of Nursing (DON) removed the first tray from the Hot Box and removed the thermal covering from the plate. The DON used a digital thermometer to perform a temperature check of ground sausage. The ground sausage had a temperature of 131 degrees (F). The DON placed the plate into the microwave for 45 seconds, removed and obtained a temperature of 138 degrees (F) for the ground sausage. The plate was again returned to the microwave for 40 seconds. The DON removed the plate and checked temperature of the ground sausage and obtained a temperature of 143 degrees (F). -8:18 AM the DON placed the plate back into the microwave for the third time and finally obtained a temperature of 165 degrees (F) for the ground sausage. -observations from 8:18 AM to 8:40 AM revealed no further temperature checks were completed for the breakfast meal. Observations on 11/21/24 at 12:36 PM on the SCU revealed the following food temperatures were obtained from a test tray after completion of the noon meal service: -cheesy potatoes had a temperature of 136 degrees (F). -ham slice had a temperature of 134 degrees (F). -diced carrots had a temperature of 131 degrees (F). -spaghetti had a temperature of 133 degrees (F). -mashed potatoes had a temperature of 133 degrees (F). -puree ham had a temperature of 133 degrees (F). -puree carrots had a temperature of 132 degrees (F). -ground ham had a temperature of 134 degrees (F). D. Review of food temperatures logs from the SCU from 11/1/24 to 11/20/24 revealed the following: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Community Memorial Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1015 F Street Burwell, NE 68823	

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-for the breakfast meal there was no evidence food temperatures were documented on 11/1, 11/2, 11/3, 11/4, 11/9, 11/10, 11/16 and 11/17 (8 out of 20 days). -for the noon meal there was no evidence food temperatures were documented on 11/1, 11/3, 11/4, 11/6, 11/9. 11/10, 11/16. and 11/17 (8 out of 20 days) -for the evening meal there was no evidence food temperatures were documented on 11/5, 11/9, 11/10, 11/15 and 11/17 (5 out of 19 days). During an interview on 11/21/24 at 9:30 AM, the DM confirmed the SCU staff were not always completing temperature checks of the food items served from the Hot Box. In addition, the DM indicated food should not be served below 135 degrees (F) to ensure the food was palatable.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29638 LICENSURE REFERENCE NUMBER 175 NAC 12-006.18(B), and 175 NAC 12.006.18(D) Based on observations, record review and interview: the facility staff failed to utilize gloves and to wash hands and/or perform hand hygiene at appropriate intervals during the provision of toileting and catheter cares for Residents 1, 26 and 54 and to implement enhanced barrier precautions when providing direct cares for Residents 29 and 59. The total sample size was 22 and the facility census was 58. Findings are: A. Review of the facility policy Hand Hygiene (undated) revealed hand hygiene was defined as the general term for cleaning hands by handwashing with soap and water or the use of an antiseptic hand rub also known as alcohol-based hand rub (ABHR). Hand hygiene was to be completed when: -hands were visibly soiled with blood or other body fluids. -between resident contacts. -after handling contaminated objects. -before applying and after removing personal protective equipment (PPE), including gloves. -before preparing or handling medications. -before performing resident care procedures. -after handling items potentially contaminated with blood, body fluids, secretions, and excretions. -when during resident care, moving from a contaminated body site to a clean body site. -before and after proving cares to residents in isolation. B. Review of the facility policy Infection Prevention and Control Program (undated) revealed gloves were to be worn to prevent the spread of infection and to protect hands from potentially infectious materials and defined use in the following situations: -when touching excretions, secretions, blood, body fluids, mucous membranes, or non-intact skin. -when employees hands had any cuts, scrapes, wounds, chapped skin, or dermatitis. -when cleaning up spills or splashes of blood or body fluids. -when cleaning potentially contaminated items. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-whenever in doubt. C. Review of the facility policy Enhanced Barrier Precautions (EBP-involves gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multidrug-resistant organism (MDRO-bacteria that have become resistant to certain antibiotics) reviewed/revised 6/3/24 revealed it was the policy of the facility to implement EBP for the prevention of transmission of MDRO's. The policy indicated an order would be obtained for EBP for residents based on the following criteria: -Chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers, and -Indwelling medical devices such as central lines, urinary catheters and feeding tubes, even if the resident was not known to be infected or colonized with an MDRO. Personal Protective Equipment (PPE-items such as gowns, gloves, face shield that are worn to protect care givers) for EBP was only necessary when performing high-contact care activities: -Dressing -Bathing -Transferring -Providing Hygiene -Changing Linens -Changing Brief or assisting with toileting cares -Device care or use: central lines, urinary catheters, feeding tubes. -Wound care: any skin opening requiring a dressing. D. During an observation of nursing care on 11/19/24 at 7:52 AM, Medication Aide (MA)-H provided toileting assistance for Resident 26. MA-H entered the resident's bathroom and without washing hands or using hand sanitizer, assisted the resident with ambulation into the bathroom. Without use of gloves, MA-H removed the resident's slacks and disposable urinary incontinent brief and positioned the resident on the toilet. Still without performing hand hygiene, MA-H exited the resident's room. When the resident activated the call light, MA-H returned to the resident's bathroom. MA-H placed on a clean pair of gloves without completing hand washing or hand hygiene and provided perineal hygiene for the resident. MA-H placed a small amount of barrier cream directly to the staff's gloved fingers and applied to the resident's buttocks. While still wearing soiled gloves, MA-H assisted the resident to stand, adjusted the resident's incontinent brief and slacks and directed the resident to start ambulating toward the dining room. MA-H removed soiled gloves when assisting the resident to the dining room but failed to complete hand hygiene or to wash hands when leaving the resident's room. During an interview on 11/19/24 at 9:00 AM, MA-H confirmed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-staff should have washed hands or completed hand hygiene when entered the resident's room and before providing cares for the resident. -staff should have worn gloves when removing the urinary incontinence brief as the resident was occasionally incontinent of urine. -staff should have washed hands before putting on clean gloves. -staff should not have worn soiled gloves to adjust the resident's incontinence brief and clothing. -staff should have completed hand hygiene after removing soiled gloves and before leaving the resident's room. Interview on 11/21/24 at 9:00 AM with Licensed Practical Nurse LPN-K, Infection Preventionist revealed the direct care staff had received ongoing training related to use of gloves and performing hand hygiene and/or handwashing. 51391 E. During an observation of the provision of care for Resident 1 on 11/19/24 at 10:30 AM, LPN-L, entered Resident 1's room to complete supra-pubic catheter cares (tube that goes into the bladder through the abdominal wall which drains urine from the bladder, cares include washing and drying the skin around the catheter site). LPN-L washed hands and put on a disposable gown and gloves, then removed the sponge dressing from around the supra-pubic catheter which was heavily soiled with urine. LPN-L, without changing gloves, cleansed and dried the skin around the catheter and applied a clean sponge dressing to the insertion site. LPN-L then removed soiled gloves, gown, and washed hands. During an interview on 11/19/24 at 12:45 PM, LPN-L, verified that Resident 1 was on EBP, indicated that a gown and gloves need to be worn when completing suprapubic catheter cares and emptying urine from the catheter bag. LPN-L verified that gloves should have been changed when completing suprapubic catheter cares when taking the old sponge dressing off. F. During an observation of the provision of care for Resident 54 on 11/19/24 at 9:20 AM, MA-M, entered Resident 54's room to assist the resident to the bathroom. MA-M did not wash hands or put on gloves. MA-M pulled down the resident pants and incontinence brief which was soiled with urine. MA-M put on gloves, changed the resident's soiled brief, assisted the resident to a standing position and completed incontinence cares. Without removing gloves, MA-M pulled up the resident's pants and assisted the resident into the wheelchair. MA-removed disposable gloves and assisted the resident with washing hands. MA-M then washed hands, transferred the resident into bed, assisted with covering the resident and placed items within reach of the resident. MA-M did not wash hands before leaving the room and then sat down at the computer to chart. G. Review of Resident 59's Care Plan dated 11/19/24 and Treatment Administration Record dated 11/2024 revealed the resident was on EBP and had a diagnosis of Extended-spectrum beta-lactamase (ESBL-an enzyme produced by some bacteria that makes them resistant to many antibiotics). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/18/24 at 9:25 AM, LPN-E, verified that Resident 59 was on EBP due to a foley catheter (a thin tube that drained urine from the bladder into a collection bag), and indicated a gown and gloves needed to be worn when completing catheter cares and emptying urine from the catheter bag. During an observation of the provision of care for Resident 59 on 11/18/24 at 10:30 AM, LPN-E and Nurse Aide (NA)-D entered Resident 59's room to complete peri-cares, catheter cares and to reposition the resident. LPN-E and NA-D washed their hands and put on disposable gowns and gloves. Resident 59 was incontinent of a small bowel movement and the staff completed catheter cares and peri cares. LPN-E did not remove or change gloves after completing peri cares or catheter cares. LPN-E and NA-D changed the residents bottom sheet and put on a clean incontinence brief. LPN-E removed the disposable gown and gloves and washed hands but failed to reapply gloves or a gown. LPN-E assisted to reposition the resident, adjusted the bed linens, pillows, and the catheter tubing without use of the required gown and gloves. During an observation of the provision of care for Resident 59 on 11/19/24 at 8:10 AM, LPN-L and MA-F, entered Resident 59's room to reposition the resident and to get the resident ready for breakfast. LPN-L and MA-F washed their hands, put on a disposable gowns and gloves, and completed peri cares and catheter cares. LPN-L changed gloves and LPN-L and MA-F changed the resident's soiled brief. LPN-L removed the disposable gown and changed gloves. LPN-L then changed the sheet and blanket covering the resident, repositioned the resident to the resident's right side and adjusted pillows and the catheter tubing without wearing the required gown. During an interview on 11/19/24 at 12:05 PM, MA-O verified Resident 59 was on EBP and a gown and gloves needed to be worn when completing cares on Resident 59 that require any contact with the resident. During an interview on 11/19/24 at 12:40 PM, LPN-L verified Resident 59 was on EBP, and indicated a gown and gloves only needed to be worn when completing catheter cares and emptying urine from the catheter bag for Resident 59. 45739 H. Review of Resident 29's MDS dated [DATE] revealed the resident was cognitively intact, was dependent with dressing, transfers, bed mobility, and toileting, had diagnoses of dementia, Parkinson's Disease, anxiety, and depression, received antipsychotic and antidepressant medications, was at risk for pressure ulcers, and had pressure relieving devices for their chair, bed, and was on a turning/repositioning program. Review of Resident 29's Care Plan last revised 10/3/24 revealed the resident received antidepressant medications, antipsychotic medications, and was dependent with bed mobility, dressing, transfers, and toileting. The resident was at risk for skin breakdown and staff were to follow treatments as ordered on the Treatment Administration Record (TAR). There was no documentation on the Care Plan that the resident had any pressure sores or was on EBP. Review of Resident 29's TAR for November 2024 revealed orders for: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-change heel cup every Tuesday for deep tissue injury (damage to the soft tissue beneath the skin caused by pressure or shear forces) ordered 9/24/24, and -paint left and right heel wounds with betadine, allow to dry, and then apply skin prep to site twice a day until healed, then place heel protector over site ordered 10/14/24. Observations of 11/18/24 at 11:10 AM a sign was located on Resident 29's Bathroom door that the resident had EBP implemented. Observation on 11/19/24 at 11:30 AM with MA-M and MA-N. Both MA's performed hand hygiene and started to gown up in the resident room. LPN-L entered Resident 29's room and told the MA's they did not need to gown up because the resident's wounds were covered. The MA's removed their gowns, and applied gloves only. The MA's uncovered the resident and rolled the resident to remove their pants, then removed the resident's soiled brief. MA-N performed peri cares without any identified concerns. MA-N removed their gloves, performed hand hygiene then applied new gloves and applied a clean brief to the resident. MA-M rolled the resident to the other side and hooked the brief to the resident. Both MA's, still not wearing gowns assisted the resident to sit on the edge of the bed and hooked the resident up to the sit to stand lift. The MA's transferred the resident to the wheelchair using the sit to stand lift. Once the resident was in the wheelchair, both MA's removed their gloves and performed hand hygiene. The MA's removed the lift from the resident, MA-N, without wearing gloves assisted with personal hygiene and MA-M made the residents bed without wearing gloves or a gown and the bedspread touched MA-M's scrub top. MA-M removed the trash from the room and disposed of, then removed the sit to stand lift from the resident room and cleaned the lift. MA-N took the resident to the dining room. Both MA's performed hand hygiene upon exiting the resident room. Interview on 11/19/24 at 11:30 AM with LPN-L revealed Resident 29 had EBP for heel wounds but PPE was only needed when working with the resident's heels. If the heels were covered then PPE was not required. LPN-L stated EBP could possibly be discontinued because the resident did not have any drainage. Interview on 11/19/24 at 11:35 AM with MA-M and MA-N revealed they wear PPE in the morning when getting the resident up for the day because the socks could have come off, but PPE was not required when the heel wounds were covered. Further interview confirmed PPE was not required while performing high-contact cares unless the wounds were uncovered. Interview on 11/20/24 at 3:10 PM with the MDS nurse confirmed the residents pressure areas and EBP were not implemented onto Resident 29's Care Plan. Interview on 11/20/24 at 3:55 PM with the Director of Nursing (DON) confirmed EBP should be followed, and PPE worn during all high contact care times such as toileting, dressing, and transferring for residents with on-going wounds.